Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2003

Summary of Auditor's Results

FINANCIAL STATEMENTS

- We issued an unqualified opinion on the state's financial statements.
- We found no significant deficiencies in the design or operation of internal control over financial reporting that we consider a reportable condition.
- We noted no instances of noncompliance that were material to the financial statements of the state.

FEDERAL AWARDS

- Except for the Medicaid program, we issued an unqualified opinion on the state's compliance with requirements applicable to each of its major federal programs.
- We noted deficiencies in the design or operation of internal control over major federal programs that we consider to be reportable conditions. The following reportable conditions noted in this schedule are considered material weaknesses: 03-1, 03-2, 03-6, 03-8, 03-9, 03-11, 03-12, 03-13, 03-14, 03-16, 03-17, 03-18, and 03-20.
- We reported findings that are required to be disclosed under OMB Circular A-133, Section 510(a).
- The dollar threshold used to distinguish between Type A and Type B programs, as prescribed by OMB Circular A-133, Section 520(b), was $30,000,000.
- The state did not qualify as a low-risk auditee under OMB Circular A-133, Section 530.
- The following were major programs, determined in accordance with OMB Circular A-133, Section 520:

CFDA	PROGRAM
10.665	School and Roads - Grants to State
11.419	Coastal Zone Management Administration Awards
11.436	Columbia River Fish Development Program
11.438	Pacific Coast Salmon Recovery Program
14.239	Home Investment Partnerships Program
17.225	Unemployment Insurance

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2003

Summary of Auditor's Results - continued

	Workforce Investment Act Cluster
17.258	Workforce Investment Act Adult Program
17.259	Workforce Investment Act Youth Activities
17.260	Workforce Investment Act Dislocated Workers
17.503	Occupational Safety and Health - State Program
20.218	National Motor Carrier Safety
20.509	Formula Grants for Non-Urban Areas
64.015	Veterans State Nursing Home Care
84.010	Title I Grants to Local Education Agencies
84.126	Rehabilitation Services – Basic Grants to States
84.181	Special Education - Infants and Families with Disabilities
84.338	Reading Excellence
84.367	Improving Teacher Quality
93.558	Temporary Assistance for Needy Families
93.563	Child Support Enforcement
93.568	Low Income Home Energy Assistance Program
	Child Care Cluster
93.575	Child Care and Development Block Grant
93.596	Child Care Mandatory and Matching Funds
93.659	Adoption Assistance
93.667	Social Services Block Grant
	Medicaid Cluster
93.775	State Medicaid Fraud Control Units
93.777	State Survey and Certification of Health Care Providers and Suppliers
93.778	Medical Assistance Program (Title XIX Medicaid)
93.919	Breast and Cervical Cancer

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2003

Financial Statement Findings

None reported. However, we do report instances of noncompliance with state laws and regulations that are not material to the state's basic financial statements in a separate accountability report. This report is available on our internet site at **www.sao.wa.gov/.**

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2003

Summary of Federal Findings

Finding Number	Finding
03-1	The Department of Community, Trade and Economic Development did not comply with federal requirements for time and effort reporting and suspension and debarment.
03-2	The Department of Community, Trade and Economic Development did not comply with federal requirements for time and effort reporting.
03-3	The Employment Security Department did not comply with federal requirements for payroll time and effort reporting for the Unemployment Insurance program.
03-4	The Employment Security Department paid unemployment insurance benefits to claimants who were not eligible and made payments to claimants during their first week of unemployment, which is prohibited by state law.
03-5	The Employment Security Department did not comply with federal requirements for payroll time and effort reporting for the Workforce Investment Act program.
03-6	The Washington Interagency Committee for Outdoor Recreation should improve its internal control over federal reporting.
03-7	The Department of Health does not adequately monitor its subrecipients for the Breast and Cervical Cancer program.
03-8	The Department of Social and Health Services, Medical Assistance Administration, received federal Medicaid funds for unallowable services provided to undocumented aliens.
03-9	The Department of Social and Health Services, Medical Assistance Administration, has not established sufficient internal controls to ensure that Medicaid payments are made only to persons with valid Social Security Numbers and are not made on behalf of deceased individuals or persons using the social security numbers of deceased individuals.
03-10	The Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office reliable records needed for audit in a timely manner.

03-11	The Department of Social and Health Services, Medical Assistance Administration, has not established sufficient internal controls to ensure financial reports submitted to the federal government comply with Medicaid provisions.
03-12	The Department of Social and Health Services, Medical Assistance Administration, has not established sufficient internal controls to ensure the eligibility of families enrolled in the Medicaid Basic Health Plus program.
03-13	The Department of Social and Health Services, Aging and Disability Services Administration and Medical Assistance Administration have not set up an effective system of communication that would ensure that Medicaid payments are not being made to nursing homes that are not in compliance with the federally mandated health and safety standards.
03-14	The Department of Social and Health Services, Medical Assistance Administration, is not complying with subrecipient monitoring requirements for the Medicaid Program.
03-15	The Department of Social and Health Services, Aging and Disability Services Administration, cannot determine whether nursing home payment rates properly excluded unallowable expenditures related to supplemental Medicaid payments.
03-16	The Department of Social and Health Services, Medical Assistance Administration has not established sufficient internal controls to ensure compliance with Medicaid provisions regarding licensing and other eligibility criteria for its health care providers.
03-17	The Department of Social and Health Services, Medical Assistance Administration has not established sufficient internal controls to ensure that capitation rates for its managed care providers are based on accurate fee-for-service encounter data.
03-18	The Department of Social and Health Services did not comply with federal time and effort reporting requirements for its Rehabilitation Services grant.
03-19	The Department of Social and Health Services, Economic Services Administration, should improve compliance with eligibility requirements for the Temporary Assistance to Needy Families Program.
03-20	The Department of Social and Health Services, Division of Childcare and Early Learning, does not have adequate internal controls over support for payments made to licensed family home providers and assurance that all recovered overpayments are credited to the proper funding source.
03-21	The Department of Social and Health Services, Division of Developmental Disabilities, made inappropriate payments to a for-profit agency with which it has a contract to provide services to its clients.

03-22	The Department of Social and Health Services, Mental Health Division, did not properly monitor its contract with a non-profit agency whose funds were used for the personal expenses of a staff member.
03-23	The University of Washington did not comply with federal cost principles for its research and development programs.

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2003

Summary of Questioned Costs

Federal Grantor	State Agency	CFDA No.	Federal Program	Questioned Costs	Finding No.
U.S. Department of Health and Human Services	Department of Community, Trade and Economic Development	93.568	Low Income Home Energy Assistance Program	$174,679	03-2
U.S. Department of Health and Human Services	Department of Social and Health Services	93.558	Temporary Assistance for Needy Families	$20,840	03-19
U.S. Department of Health and Human Services	Department of Social and Health Services	93.778	Medicaid	$733,107	03-8 03-9 03-12 03-21
U.S. Department of Health and Human Services	Department of Social and Health Services	93.958	Block Grants for Community Mental Health Services	$165,000	03-22
U.S. Department of Health and Human Services and U.S Department of Defense	University of Washington	93.361 93.279 12.000	Research and Development Cluster	$35,977	03-23
U.S. Department of Housing and Urban Development	Department of Community, Trade and Economic Development	14.239	Home Investment Partnerships	$287,376	03-1
U.S. Department of Labor	Employment Security Department	17.225	Unemployment Insurance	$58,600 $767,677 **(Note 2)**	03-3 03-4
U.S. Department of Labor	Employment Security Department	17.255 **(Note 1)**	Workforce Investment Act	$27,517	03-5
			TOTAL	**$2,270,773**	

Note 1 – This finding relates to a compliance issue that occurred in state fiscal year 2001. CFDA 17.255 was the applicable catalog number at that time. Refer to finding 03-5 for details.

Note 2 – The costs listed in finding 03-4 relate to unemployment benefits paid from state unemployment tax revenues that are deposited into Unemployment Trust Fund. Although these payments are not costs charged to a federal award, they are subject to audit under OMB Circular A-133 and reported in a manner similar to federal questioned costs.

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2003

Summary of Reported Fraud

We issued special investigation report, No. 6370, on May 28, 2003, in response to a suspected fraud occurring in the Child Care and Development Block Grant cluster, CFDA 93.575 and 93.596. In that report, we expressed our concerns regarding the inadequacy of the licensed family home providers' attendance records and the recovery of overpayments made to providers. We followed up on these issues in our current audit and repeated the internal control weaknesses in finding 03-20.

Schedule of Findings and Questioned Costs
For the Fiscal Year Ended June 30, 2003

Federal Findings and Questioned Costs

03-01

The Department of Community, Trade and Economic Development did not comply with federal requirements for time and effort reporting and suspension and debarment.

Background

The Department of Community, Trade and Economic Development administers the federal Home Investment Partnership Program (CFDA 14.239), also referred to as the HOME program. The objectives of the program are to expand the supply of decent and affordable housing, particularly to low- and very-low income residents; to strengthen the abilities of state and local governments to design and implement strategies to provide an adequate supply of affordable housing; to provide financial and technical assistance to states; and to strengthen partnerships among all governments involved with providing and administering affordable housing. The Department reported total HOME expenditures of $12,514,445 for fiscal year 2003.

Description of Condition

During our audit, we found the following internal control weaknesses and instances of noncompliance:

a. Payroll time and effort reporting

For payroll costs charged directly to federal awards, federal regulations require employees to document the time and effort spent on each federal activity monthly. These monthly records must reflect the actual distribution of the employee's activities. However, if an employee works on only one federal activity, semi-annual certifications signed by the employee or a supervisor meet federal requirements.

During our review of payroll charges, we noted that the Department did not require two salaried employees who worked solely on the HOME Partnership grant to prepare semi-annual certifications. In addition, we found approximately 19 employees who worked on multiple activities were keeping monthly time and effort records based on budgeted amounts, rather than actual amounts. For employees who worked on multiple activities, the total salaries and benefits charged to the federal award for state fiscal year 2003 are estimated to be $287,376.

b. Suspension and debarment

Recipients of federal assistance are required to obtain a certification from all subrecipients and potential contractors that would receive in excess of $100,000 in compensation that states they have not been suspended or debarred from participating in federal programs. When reviewing the Department's internal controls over contracting, we found that it did review the federal list of suspended and debarred parties before awarding contracts, but was not obtaining suspension and debarment certifications for its construction-related contracts as required. For fiscal year 2003, the Department spent approximately $3,268,272 for construction projects that were subject to the suspension and debarment requirement.

Cause of Condition

The Department was unaware of the federal requirements regarding time and effort reporting. For suspension and debarment, the Department relied on standard contract language prepared by another state agency that did not contain the required certification.

Effect of Condition

Time and effort reporting

Without proper time and effort records, we are unable to substantiate the accuracy of the payroll costs charged to this program. As a result, we are questioning $287,376 charged to the grant.

Suspension and debarment

If the Department does not obtain suspension and debarment certifications, it may be liable for amounts paid to subrecipients and vendors who have been suspended or debarred from receiving federal funds.

Recommendation

We recommend the Department:

- Maintain time and effort records that comply with federal regulations and consult with the federal grantor to determine whether questioned costs should be repaid.

- Obtain suspension and debarment certifications for all current contractors and update all contract language to incorporate this certificate.

Department's Response

CTED is taking the following corrective actions to address the conditions noted in the HOME program finding on Suspension and Debarment and Time and Effort requirements:

A.1. On December 9, 2003, the Administrative Services Division communicated the Suspension and Debarment requirements to all CTED employees. All program managers are required to review their current practices to determine if they are in compliance with the Suspension and Debarment requirements and when necessary to correct any non-compliance issues.

A.2 The Housing Division, HOME program, will require suspension and debarment certifications for all of its construction-related contractors. The Housing Division will:

- *Require all future subrecipients and contractors receiving awards for HOME funds for construction projects to sign and submit the U.S Department of Housing and Urban Development (HUD) form 2992, Certification Regarding Debarment and Suspension before contracts are executed. This was made effective as of January 2004.*
- *Obtain a completed HUD form 2992 certification from all of the current 2003 subrecipients and contractors using HOME funds for construction projects. This will be completed by April 30, 2004.*
- *Update the HFU contract - General Terms and Conditions, Section 7.01 Certification Regarding Debarment, Suspension, or Ineligibility to include the requirement for subrecipients and contractors to sign and submit HUD form 2992. This will be completed by January 31, 2004.*

B.1 For compliance with the time and effort requirement for staff that work solely on one federal program, CTED will revise the timesheet template to include a time and effort certification statement. All supervisors, or their designee, will be required to review the timesheets and sign the certification semi-monthly.

B.2 For compliance with the time and effort requirements for staff who work in multiple programs, the Housing Division staff who charge their time to HOME and other programs will conduct quarterly time studies to verify the timesheet charges made to HOME. This process will be effective February 2004.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issues identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment B, Section 11(h), states in part:

1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

    a) More than one Federal award,
    b) A Federal award and a non-Federal award,
    c) An indirect cost activity and a direct cost activity,
    d) Two or more indirect activities which are allocated using different allocation bases, or
    e) An unallowable activity and a direct or indirect cost activity.

5) Personnel activity reports or equivalent documentation must meet the following standards:

    a) They must reflect an after-the-fact distribution of the actual activity or each employee,
    b) They must account for the total activity for which each employee is compensated,
    c) They must be prepared at least monthly and must coincide with one or more pay periods, and
    d) They must be signed by the employee.
    e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

        i. The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;

        ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and

        iii. The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

Title 24, Code of Federal Regulations, Section 24.510(b) states:

> Certification by participants in lower tier covered transactions. (1) Each participant shall require participants in lower tier covered transactions to include the certification in appendix B [*not included in this finding*] to this part for it and its principals in any proposal submitted in connection with such lower tier covered transactions.

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-2

The Department of Community, Trade and Economic Development did not comply with federal requirements for time and effort reporting.

Background

The Department of Community, Trade and Economic Development administers the Low Income Home Energy Assistance Program (CFDA 93.568), also referred to as LIHEAP. The program assists eligible households in meeting the costs of heating and cooling of homes. The program seeks to improve energy self-sufficiency of low-income individuals and to reduce health and other risks arising from energy needs.

The program targets low-income households with the highest home energy costs or needs in relation to income, and taking family size into account. Other targets are low-income households with members who are vulnerable such as the elderly, disabled, and young children. The Department reported total program expenditures of $36,754,449 for fiscal year 2003.

Description of Condition

For payroll costs charged directly to federal awards, federal regulations require employees to document the time and effort spent on each federal activity monthly. These monthly records must reflect the actual distribution of the employee's activities. However, if an employee works on only one federal activity, semi-annual certifications signed by the employee or a supervisor meet federal requirements.

During our review of payroll charges, we noted that the Department did not require three salaried employees who worked solely on the LIHEAP grant to prepare semi-annual certifications. In addition, we found approximately nine employees who worked on multiple activities were charging their time based on budgeted amounts, rather than actual amounts. For employees who worked on multiple activities, the total salaries and benefits charged to the federal award in fiscal year 2003 are estimated to be $174,679.

Cause of Condition

The Department was unaware of the federal requirements regarding time and effort reporting.

Effect of Condition

Without proper time and effort records, we are unable to substantiate the accuracy of payroll costs charged to this program. As a result, we are questioning $174,679 charged to the grant. For the salaried employees who did not prepare a semi-annual certification, we were able to obtain alternative evidence that supported time and effort charged to the grant.

Recommendation

We recommend the Department maintain time and effort records that comply with federal regulations and consult with the federal grantor to determine whether questioned costs should be repaid.

Department's Response

CTED is taking the following corrective actions to address the conditions noted in the LIHEAP Program finding on Time and Effort requirements:

For compliance with the time and effort requirement for staff that work solely on one federal program, CTED will revise the timesheet template to include a time and effort certification statement. All supervisors, or their designees, will be required to review the timesheets and sign the certification semi-monthly.

For compliance with the time and effort requirements for staff who work in multiple programs, the Community Services Division staff who charge their time to LIHEAP and other programs will conduct quarterly time studies to verify the timesheet charges made to LIHEAP. This process became effective January 2004.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issues identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment B, Section 11(h), states in part:

1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

    a. More than one Federal award,
    b. A Federal award and a non-Federal award,
    c. An indirect cost activity and a direct cost activity,
    d. Two or more indirect activities which are allocated using different allocation bases, or
    e. An unallowable activity and a direct or indirect cost activity.

5) Personnel activity reports or equivalent documentation must meet the following standards:

    a. They must reflect an after-the-fact distribution of the actual activity or each employee,
    b. They must account for the total activity for which each employee is compensated,
    c. They must be prepared at least monthly and must coincide with one or more pay periods, and
    d. They must be signed by the employee.
    e. Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

        i. The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;

        ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and

iii. The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

NOTE: Federal regulations exempt certain grant programs, including LIHEAP, from the cost principles of OMB Circular A-87, provided the state adopts procedures consistent with Circular A-87. The state of Washington has not adopted its own principles in lieu of Circular A-87. Further, the exemption does not include the principle of allocability, which requires costs to be allocated to federal awards in relation to the benefits received.

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-3

The Employment Security Department did not comply with federal requirements for payroll time and effort reporting for the Unemployment Insurance program.

Background

The Employment Security Department administers the Unemployment Insurance Program (CFDA 17.225), which is partially funded by the U.S. Department of Labor. The program's objectives are to provide unemployment compensation to unemployed workers for periods of involuntary unemployment and to help stabilize the economy by maintaining the spending power of workers while they are between jobs. The Department reported total program expenditures of $2,420,855,385 for fiscal year 2003. Of this amount, $1,586,931,830 represents state and/or employer contributions and $833,923,555 is federal grant funds.

Description of Condition

For payroll costs charged directly to federal awards, federal regulations require employees to document the time and effort spent on each federal activity monthly. These monthly records must reflect the actual distribution of the employee's activities. However, if an employee works on only one federal activity, semi-annual certifications signed by the employee or a supervisor meet federal requirements.

During our review of payroll charges, we found six employees whose daily time distributions for multiple activities were charged directly to the federal programs using same percentage every pay period, rather than reflecting the actual time worked. Using a budget or estimate of time worked is permissible, provided the grantee keeps monthly records that demonstrate the employee's actual effort and reconciles these records with the budgeted amounts quarterly. The total salaries and benefits charged to the Unemployment Insurance federal award in fiscal year 2003 for the six employees noted above was $58,600.

This condition was also reported in the State of Washington Single Audit report in fiscal years 2000 through 2002. However, it should be noted that the Department has made significant improvements in its internal controls to inform its employees of federal time and effort requirements and to monitor compliance.

Cause of Condition

In prior audits, the Department has found it difficult to efficiently allocate time for certain staff positions because employees in these positions work on or support a great number of programs or projects. As noted above, the Department is taking steps to remedy the condition and to develop a reporting system that tracks actual effort for these positions.

Effect of Condition

Without proper time and effort records, we are unable to substantiate the accuracy of the payroll costs charged to this program. As a result, we are questioning $58,600 charged to the federal program.

Recommendations

We recommend the Department reimburse the appropriate federal programs for any costs the grantor determines to be unallowable. We also recommend the Department ensure employees accurately report their time. We further recommend the Department consult with the grantor to determine a reasonable and acceptable way to account for payroll costs charged to federal funds.

Department's Response

Salary costs for six employees within two divisions were questioned by the State Auditor's Office due to the appearance of repetitive time charging. We are providing explanatory information for the finding related to the time reporting practices, resulting questioned costs and corrective action taken for each employee as follows:

WorkSource Operations Division:

WorkSource Specialist 2, Lynnwood
At the time of the audit this employee charged his time consistent with the appropriate codes for the work performed, however, it appears he reported his daily activities in a manner that may not reflect actual activities performed. However, a substantial portion of this employee's job duties consist of providing services within the Unemployment Insurance program, including the following:

- *He is a designee within this WorkSource office to provide direct Unemployment Insurance (UI) services to clients, answers UI questions within his scope of assignment and redirects UI customers to the Telecenter.*
- *Copies and mails Unemployment Insurance related Commissioner Approved Training/Training Benefit application packets and non-monetary responses to the appropriate UI Adjudication Center.*
- *Explains UI job search requirements and provides direction in accessing information about the Unemployment Insurance program via the Internet and the TeleCenter. Manually tracks direct UI services he provides in the WorkSource Center by keeping a daily log of these activities.*

Administrative Assistant 4, West Region
This employee works as part of the West region office team that administers, provides oversight and management support to local area operations for program implementation including those funded by the Unemployment Insurance program. The work performed by this employee directly relates to programs to which her time was charged. The following is a summary of the duties performed by this employee:

- *Provides management assistance to the West Region Director, who oversees the program operations of five local areas and two District Tax Offices. Organizes, plans, prioritizes and coordinates workflow and office staff activities with regional management staff, area administrators, and other divisions within the agency.*
- *Monitors, tracks and reviews funds management of contractors working with agency partners, to ensure expenditures are within program budget.*
- *Serves as West Region office property manager, coordinates regional office operations, arranges for maintenance contracts and facility repairs, to include the tracking of state vehicles assigned to the region office. Analyzes need for new office equipment, such as phone system, copy machines, etc.*
- *Coordinates, tracks, and reviews all Commissioner and Governor's Office assignments for West Region assuring compliance with agency policy and procedures. Participates as a member of West Region Leadership Team, other various agency work groups, committees and task forces in problem solving on regional and agency related issues providing technical assistance.*

Due to the administrative nature of this position, it has been difficult to accurately charge the various programs that are supported by the work performed by this employee. The agency has attempted to charge benefiting programs, including Unemployment Insurance, equitably for these services.

Office Assistant Senior, West Region
This employee works as part of the West Region office team. Her duties are to provide administrative support to the West Region office operations. The work performed in her job duties includes the project and function codes her time is being charged to.

This employee serves as back up and support to the Administrative Assistant and assumes administrative support lead responsibility during her absence. Her responsibilities/duties involve working with time sheets, inventory, supplies, assignment management, requisitions and invoice payment and document preparation and distribution for regional programs.

As with the Administrative Assistant position noted above, the agency has attempted to charge benefiting programs, including Unemployment Insurance, equitably for these services.

WorkSource Specialist 3, Mount Vernon
This employee provides employment and reemployment services to all Mount Vernon WorkSource customers with an emphasis on Unemployment Insurance claimants. Her work responsibilities/duties involve providing labor market and job search information in group and one-on-one settings. She is also responsible for insuring that services provided are recorded in the labor exchange and Unemployment Insurance data collection systems, and refers potentially eligible individuals to training. Her job duties are directly related to the programs to which her time is charged.

WorkSource Specialist 4, Lakewood
The time charges by this employee are based on his actual hours worked. He is the only permanent WorkSource Specialist 4 (WSS4) lead worker in Pierce County. As such, he serves as the back-up for the UI Job Search Review function and serves as the office's liaison for UI services. He also consults with staff in the resolution of the more complex cases of monetary and non-monetary eligibility for the unemployment insurance program.

His other responsibilities include scheduling staff, assisting in the resource room, covering the front desk. As a result of the various jobs performed, the employee charges to multiple programs. The agency believes the funding sources used to account for this employee's time were the appropriate ones.

The above employees from the Lynnwood, West Region, Lakewood and Mt Vernon offices have been made aware that time charged on a daily basis is to be distributed by project codes that represent the various programs on which they work, and should reflect actual time spent on that activity. They will fill out their time sheets and charge their time according to duties performed each day.

Information Technology Services Division:

Information Technology Services Specialist – Bremerton WorkSource
A portion of this employee's job duties is to provide information technology services to agency employees, including several providing Unemployment Insurance services, within the Bremerton WorkSource office. In order to charge this employee's time to benefiting programs a portion of his time was allocated to the Unemployment Insurance program. The allocation was based upon the percentage of employees in the WorkSource office charging to the UI program. Staffing in the office is relatively constant and the programs charged by staff do not fluctuate significantly. However, to ensure that time is allocated appropriately, effective July 1, 2003 that portion of the employee's time used to support WorkSource staff, including those charging to the UI program, will be charged to an overhead allocation code which is reevaluated on a monthly basis.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issues identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments,* Attachment B, Section 11(h), states:

(1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

(2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

a) More than one Federal award,
b) A Federal award and a non-Federal award,
c) An indirect cost activity and a direct cost activity,
d) Two or more indirect activities which are allocated using different allocation bases, or
e) An unallowable activity and a direct or indirect cost activity.

(5) Personnel activity reports or equivalent documentation must meet the following standards:

a) They must reflect an after-the-fact distribution of the actual activity of each employee,
b) They must account for the total activity for which each employee is compensated,
c) They must be prepared at least monthly and must coincide with one or more pay periods, and
d) They must be signed by the employee.
e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

(i) The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;
(ii) At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and
(iii) The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

03-4

The Employment Security Department paid unemployment insurance benefits to claimants who were not eligible and made payments to claimants during their first week of unemployment, which is prohibited by state law.

Background and Description of Condition

The Department pays more than $2.3 billion a year in benefits to unemployed workers through the Unemployment Insurance program (CFDA 17.225). During our audit, we reviewed unemployment insurance benefit payments and found that at least $221,677 in benefits were paid to claimants who were not eligible for benefits due to incarceration, invalid Social Security numbers or because they already were receiving benefits for an on-the-job injury.

We found:

- Sixteen claimants received benefits while incarcerated, which makes them ineligible for unemployment benefits. The claimants were paid $84,062.

- Ninety-two claimants who received benefits used invalid Social Security numbers or Social Security numbers belonging to deceased individuals. These claimants are not eligible according to the Department's benefit eligibility policies. These payments totaled $96,352.

- Five claimants received both unemployment and workers' compensation benefits for the same time period. This is a violation of state law. These payments totaled $35,944.

- The Department made duplicate benefit payments to claimants on 13 occasions, resulting in overpayments of $5,319.

In addition to the overpayments described above, we found that the Department paid several claimants during their first week of unemployment, which is prohibited by state law. When we examined this area, we produced a report that compared the weeks of unemployment to the benefit payment weeks and found 3,763 matches. We selected 60 of the 3,763 claimants and found that 25 (42 percent) were paid during the first week of unemployment. Since the report totaled $992,888 for a nine-month period, we estimate that the amount would have been more than $1.3 million for a 12-month period. Therefore, we estimate that $546,000 (42 percent of $1.3 million) was paid to claimants during their first week of unemployment.

Cause of Condition

In September 2002, the Department obtained the ability to cross-match claimants' Social Security numbers with data from the Social Security Administration. However, the Department stated that it did not have the necessary resources to use the results to identify claimants with invalid Social Security numbers until April 2003. The Department does not have procedures to identify incarcerated claimants, deceased claimants and claimants receiving industrial insurance benefits.

The General Unemployment Insurance Design Effort (GUIDE) system is the Department's unemployment insurance benefit payment system. An error in the system caused several claimants to be paid for their first week of unemployment, which is prohibited by law. This error has caused claimant overpayments since the system went on line in 1997. Management has been aware of this error since 1997, but considers the overpayments administrative errors and have not billed claimants for the overpayments.

Department management agreed that the instances in which claimants received duplicate payments for the same benefit week were the result of processing errors.

Effect of Condition

Without adequate internal controls over the disbursement of unemployment insurance benefits, the Department

cannot ensure that benefits are being paid to eligible claimants. In fiscal year 2003, we estimate that more than $767,677 was paid to ineligible claimants.

Recommendations

We recommend the Department:

- Continue its effort to cross-match its Social Security data with data from the Social Security Administration to identify claimants with invalid Social Security numbers.
- Consider obtaining Social Security number data for deceased individuals from the Social Security Administration.
- Consider sharing or obtaining data with other public entities to match Social Security numbers on incarcerated claimants and claimants receiving conflicting benefits.
- Improve the benefit payment system to prohibit duplicate payments and payments during the claimant's first week of unemployment.

Department's Response

We appreciate the work performed by the State Auditor's Office on our Unemployment Insurance benefit payment processes. As usual, the audit has identified things that we can do to improve the UI program. Our agency currently performs extensive cross matches, data mining and other fraud prevention and detection efforts for the UI program. Over the last two years we have had substantial budget cuts from the U.S. Department of Labor and supplemental budget requests to enhance our fraud prevention and detection efforts were not funded by the Legislature. However, our Office of Special Investigations and their fraud prevention and detection efforts continue to be recognized as a leader in the nation, by the USDOL and other states.

In response to the issues identified by the auditor the agency has taken the following actions:

Sixteen claimants received benefits while incarcerated, which makes them ineligible for unemployment benefits. The claimants were paid $84,062.

Agency staff conducted thorough investigations of each claimant's eligibility to receive benefits. These investigations verified that 15 of the 16 claimants were incarcerated while receiving benefits. One claimant was found to have been released pending an appeal and was therefore eligible for benefits. Total benefits received by this individual were $4,368. The remaining incarcerated claimants have subsequently been denied further benefits and have been assessed with overpayments.

We would appreciate assistance from the State Auditor's Office in demonstrating how this cross match was accomplished and whether our agency would be able to negotiate a similar cross match. In order for it to be an effective prevention tool the entire benefit payment file would need to be run on a weekly basis. We do not know how many Social Security Numbers were initially identified by the auditors, nor the level of effort expended to arrive at the 16 claimants identified in this report. Our concern is whether implementing a cross match of this type would be cost effective given that the agency's investigative unit is already at capacity. As such, the Department would be unable to accomplish this additional workload without the federal grantor (U.S. Department of Labor) or the Legislature providing more funding.

Ninety-two claimants who received benefits used invalid Social Security Numbers or Social Security Numbers belonging to deceased individuals. These payments totaled $96,352.

Of the ninety-two claimants cited by the auditors as using social security numbers of the deceased or numbers that were invalid, the agency had already identified and written overpayments on the majority of these individuals prior to the SAO audit.

On September 27, 2002, the first cross match of Unemployment Insurance (UI) benefit data with Social Security Administration (SSA) records was completed. Although the department was receiving a report of cross match results from the SSA, our mainframe system required reprogramming to support the process.

The agency had four major concerns when the cross match process was started:

1) No funding for investigators;
2) The agency's ability to handle the increased workload;
3) The reliability of SSA data.

Because of these concerns a decision was made not to stop payment of claims initially until eligibility could be verified. During the first four to six months of the new cross match process the agency was working through the learning curve to iron out issues, answer questions, and finalize the process.

The numbers provided by the SAO demonstrates the effectiveness of the new cross match process and reduces the risk of making payments to ineligible individuals:

Month/Year	*Number of claimants using SSN belonging to a deceased person*
October 2002	*11*
November 2002	*41*
December 2002	*26*
January 2003	*16*
February 2003	*6*
March 2003	*2*
April 2003	*3*

As reflected above, the number of claimants using an SSN belonging to a deceased person that were not detected immediately was significantly reduced.

At the end of April 2003 the Social Security cross match process was completed with reprogramming of the agency's mainframe system, by adding a Social Security Number Verification Indicator Field and a screen for secondary verification of numbers in question. With these system improvements issue stops are automated. This results in a denial of benefits when we can do so legally.

The Department would like to point out that the new procedures for the Identity Claims Unit, assigned to investigate Social Security cross match issues, are written to reflect the requirements of the O'Brien class action court decision, as is the programming in our benefit payment system (GUIDE). Also, federal law governing administration of the UI program requires that claimants be paid "when due". It is not legal for the agency to withhold these payments until we hear back from the Social Security Administration. Fifty-five of the claims identified in this audit were covered under the O'Brien decision.

The Department does have a procedure to identify claimants using Social Security Numbers of the deceased or numbers that are invalid. The Department is continuing efforts to obtain on-line access to Social Security data. On-line access will allow the Department to determine in an even more timely and accurate manner whether the number being used by a claimant is invalid or belongs to a deceased person.

In addition, the Department is also considering obtaining Vital Statistics information through the Department of Social and Health Services to assist in accurately identifying claimants who use Social Security Numbers belonging to deceased persons.

Five claimants received both unemployment and workers' compensation benefits for the same time period. This is a violation of state law. These payments totaled $35,944.

These payments were found during the SAO benefit audit cross match and have been thoroughly investigated by the agency. In each case, individuals did receive benefits to which they were not entitled. All have had overpayments assessed and fraud has been investigated. In some cases the individuals filed regular claims and did not inform our

agency they had received, or were receiving, time loss payments. In the remaining cases, the individuals had been released from time loss, filed unemployment claims, then returned to time loss and did not inform the agency of that return.

Our system of communication with Labor and Industries works well for all cases where an individual informs us they have received time loss payments. Also, in most instances Labor and Industries informs us when they reinstate time loss payments.

We are currently in communication with Labor and Industries to determine if there is a method in which we can find cases of nondisclosure on the claimant's part. We are also looking at a better method of communication as to when an individual is released from then returns to time loss payments.

The Department made duplicate benefit payments to claimants on 13 occasions resulting in overpayments of $5,319.

These exceptions were caused by claimants being paid for the same week on two different claims – one for regular UI benefits and another for Temporary Extended Unemployment Compensation (TEUC). This issue was identified as a GUIDE incident (system error) by the agency and it was subsequently corrected. Several of these duplicate payments were identified as overpayments by the agency prior to the audit and subsequently recovered. As of April 3, 2004 the TEUC program will be eliminated.

The Department paid several claimants during the first week of unemployment…

There were a number of circumstances that contributed to this exception. Many of these included cases where claimants were paid TEUC when they should have qualified for a new claim. Others were claims that were backdated in the system, late claims, and changes in the effective date of the claim, etc. that weren't handled correctly. Some of these were human error some were system errors.

We have identified a way to prevent these exceptions from continuing with an automated solution. This solution has been prioritized and work will begin on it shortly.

Auditor's Concluding Remarks

We appreciate the Department's efforts in addressing this finding and will review the agency's progress toward improving internal controls during our next regular audit.

Applicable Laws and Regulations

Revised Code of Washington 50.20.010(1) states in part:

> An unemployed individual shall be eligible to receive waiting period credit or benefits with respect to any week in his or her eligibility period only if the commissioner finds that: . . . (c) He or she is able to work, and is available for work in any trade, occupation, profession, or business for which he or she is reasonably fitted [and] (d) He or she has been unemployed for a waiting period of one week.

Revised Code of Washington 50.20.085 states:

> An individual is disqualified from benefits with respect to any day or days for which he or she is receiving, has received, or will receive compensation under RCW 51.32.060 or 51.32.090.

Revised Code of Washington 51.32.060 is the state law providing compensation for permanent total disability in the case of an industrial accident, which is referred to as workers' compensation pensions.

Revised Code of Washington 51.32.090 is the state law providing compensation for temporary total disability in the case of an industrial accident, which is referred to as workers' compensation time loss.

Washington Administrative Code 192-110-005 (3) states in part:

> The first week you are eligible for benefits is your waiting week. You will not be paid for this week . . .

Unemployment Insurance Procedures Manual, Section 5100.00, General Information -- Initial Claim, states in part:

> Without a social security number (SSN), a claim for unemployment insurance cannot be completed. A correct SSN is essential to establish an unemployment insurance claim. During the initial claim process, verification of identity will occur . . . SSNs that have never been issued, belong to another individual or belong to a deceased person will be flagged . . .

Section 20.20.20.a of the Office of Financial Management's *State Administrative and Accounting Manual* states in part:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

03-5

The Employment Security Department did not comply with federal requirements for payroll time and effort reporting for the Workforce Investment Act program.

Background Note

The Department expended $70,353,813 from the Workforce Investment Act program (CFDA 17.255) in state fiscal year 2001. The issue described in this finding relates to costs charged to the program in state fiscal year 2001. We performed additional tests of compliance in the 2001 audit period to meet the requirements of OMB Circular A-133 as recommended by the U.S. Department of Labor as part of its quality control review process. Because we issued our single audit report for fiscal year 2001 prior to completion of this work, we are reporting this finding in our fiscal year 2003 report as recommended by the U.S. Department of Labor and the U.S. Department of Health and Human Services, which serves as the federal cognizant agency for the state. We have audited the Workforce Investment Act cluster (CFDA 17.258, 17.259, and 17.260) as part of our fiscal year 2002 and 2003 single audits, and the issue described in this finding has been resolved in 2003.

Description of Condition

For payroll costs charged directly to federal awards, federal regulations require employees to document the time and effort spent on each federal activity monthly. These monthly records must reflect the actual distribution of the employee's activities. However, if an employee works on only one federal activity, semi-annual certifications signed by the employee or a supervisor meet federal requirements.

During our review of fiscal year 2001 payroll charges, we found two employees whose daily time distributions for multiple activities were charged directly to the federal programs using same percentage every pay period, rather than reflecting the actual time worked. Using a budget or estimate of time worked is permissible, provided the grantee keeps monthly records that demonstrate the employee's actual effort and reconciles these records with the budgeted amounts quarterly. The total salaries and benefits charged to the Workforce Investment Act award in fiscal year 2001 for the two employees noted above was $27,517.

It should be noted that the Department has made significant improvement in its internal controls to inform its employees of federal time and effort requirements and to monitor compliance. We consider this issue resolved for 2003.

Cause of Condition

The Department has found it difficult to efficiently allocate time for certain staff positions because employees in these positions work on or support a great number of programs or projects. As noted above, the Department is taking steps to remedy the condition and to develop a reporting system that tracks actual effort for these positions.

Effect of Condition

Without proper time and effort records, we are unable to substantiate the accuracy of the payroll costs charged to this program. As a result, we are questioning $27,517 charged to the Workforce Investment Act program for fiscal year 2001.

Recommendations

We recommend the Department consult with the U.S. Department of Labor to determine if the questioned costs identified above should be returned to the Workforce Investment Act program.

Department's Response

We appreciate the State Auditor's Office recognition of our efforts to improve agency time reporting. As noted, the state fiscal year 2003 audit report did not have a time reporting finding for the WIA program, and stated that ESD has made significant improvement in its internal controls to inform employees of the requirements. The auditors stated the issue raised in this finding for fiscal year 2001 is considered resolved for the WIA program in fiscal year 2003.

The following additional information is material to this fiscal year 2001 audit issue. Both staff members whose salaries have been questioned, stated in writing their WIA time charges for the fiscal year in question were reasonably correct, and noted their considerable work efforts for specific WIA products. WIA was an important cost objective for both individuals. Both stated they understood their time charges resulted in tangible WIA work products and their charges to WIA funds were reasonably accurate. Both stated that they charged time only to grants on which they worked as follows:

1. *The Administrative Secretary/Program Assistant was the lead support staff and supervised administrative staff performing work that included Workforce Investment Act activities. This employee's work was directed to a number of federal grants, with a considerable amount of her time spent on Workforce Investment Act (WIA) activities.*

   This staff member supported the WIA program in her work throughout fiscal year 2001. Some examples of her WIA work efforts included: creating and organizing the Division monthly report to senior management and meeting agendas, letters to inquiring citizens, and Worker Adjustment and Retraining Notifications (WARN). She also formatted and organized additional correspondence and charts related to the Workforce Investment Act programs. Copies of related work as well as the employee's written statement are available if needed.

2. *The Administrative Secretary was also a staff member whose work included WIA administrative functions. The Workforce Investment Act charges can be supported by documentation of her work. Evidence of her work included: WARN notices, review of staff time sheets and travel vouchers, organizing symposiums and WIA files, requesting WIA strategic plans from each of the twelve local entities, and participation in the contracting process for WIA activities and review of submitted documentation. To the best of her knowledge, she stated her salary costs charged to WIA were in support of the WIA program. A copy of the employee's statement and related work is available if needed.*

These two individuals were the main support staff for WIA as well as other smaller Department of Labor employment and training programs for the agency's Employment and Training Division. The state administrative headquarters of the WIA program includes many staff with administrative, program and oversight responsibilities. We believe these costs are allowable because they were both reasonable and necessary, and directed to the WIA program. The work of these individuals resulted in significant contributions to the WIA program for this period.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issues identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments,* Attachment B, Section 11(h), states:

(1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.
(2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.
(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.
(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency. Such documentary support will be required where employees work on:

a) More than one Federal award,
b) A Federal award and a non-Federal award,
c) An indirect cost activity and a direct cost activity,
d) Two or more indirect activities which are allocated using different allocation bases, or
e) An unallowable activity and a direct or indirect cost activity.

(5) Personnel activity reports or equivalent documentation must meet the following standards:

(a) They must reflect an after-the-fact distribution of the actual activity of each employee,
(b) They must account for the total activity for which each employee is compensated,
(c) They must be prepared at least monthly and must coincide with one or more pay periods, and
(d) They must be signed by the employee.
(e) Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to Federal awards but may be used for interim accounting purposes, provided that:

i. The governmental unit's system for establishing the estimates produces reasonable approximations of the activity actually performed;

ii. At least quarterly, comparisons of actual costs to budgeted distributions based on the monthly activity reports are made. Costs charged to Federal awards to reflect adjustments made as a result of the activity actually performed may be recorded annually if the quarterly comparisons show the differences between budgeted and actual costs are less than ten percent; and

iii. The budget estimates or other distribution percentages are revised at least quarterly, if necessary, to reflect changed circumstances.

03-6

The Washington Interagency Committee for Outdoor Recreation should improve its internal controls over federal reporting.

Background

The Pacific Coast Salmon Recovery-Pacific Salmon Treaty program (CFDA 11.438) is a cooperative program funded by the U.S. Department of Commerce. This program assists states in salmon restoration and in fulfilling responsibilities under the Pacific Salmon Treaty. Activities performed with funds from this grant program include salmon habitat restoration, salmon research, recovery planning and salmon enhancement. The Washington Interagency Committee for Outdoor Recreation reported total grant expenditures of $17.6 million for fiscal year 2003.

Description of Condition.

As part of its responsibilities, the Committee is required to submit federal financial reports (referred to as the SF-269) to the Department of Commerce semi-annually. These reports provide information to the federal grantor about the amounts obligated and spent by the Committee and identify the amount of matching funds contributed by the Committee and its subrecipients. The Committee did not have adequate internal controls over the preparation of these reports and did not submit them in a timely manner. Currently, one individual prepares, signs, and submits the federal reports without supervisory review.

The Committee is required to use the accrual method of accounting and submit its SF-269 report every six months. We reviewed the SF-269 reports submitted in June 2003 for the six-month periods ending September 30, 2002 and March 31, 2003. We found that the federal expenditures reported on the September 30, 2002 report were understated by approximately $1.8 million and federal expenditures reported on the March 31, 2003 report were overstated by approximately $2 million. Further, both reports were not submitted in a timely manner.

Cause of Condition

Until recently, the Committee was not aware of the requirements for submission of the SF-269 report. Further, the reports were not reviewed by a second person to ensure they were accurate.

Effect of Condition

The financial reports did not reflect actual activities in accordance with the accrual basis of accounting and were not submitted in a timely manner. Without accurate and timely reporting, the federal grantor is unable to assess program operations and make decisions about future funding.

Recommendation

We recommend the Committee:

- Improve internal controls over federal reporting, including supervisory review for accuracy and timeliness.
- Submit federal reports in accordance with grant requirements.
- Use the accrual basis method when preparing the financial status report and reconcile amounts back to its accounting system.

Committee's Response

Thank you for the opportunity to respond to the Pacific Coast Salmon Recovery audit. IAC recognizes the importance of administering the funds appropriately. This audit pointed out two technical areas the agency could improve on, and we agree. You noted two reports due to the Department of Commerce were submitted late. All reports since then have been submitted timely. IAC is committed to submitting reports timely and in accordance with grant requirements. In reporting accruals, this office had followed a different interpretation of the rules. This

was a technical issue involving the actual period that we reported the expenditure compared to when we actually released the payment. IAC will report all future accruals by the method identified by the auditors. We note all federal reimbursements were submitted and reimbursed appropriately in any event. IAC would like to thank the auditors that worked on this audit. They provided valuable guidance and recommendations.

Auditor's Concluding Remarks

We appreciate the Committee's commitment to resolve the issue identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Committee staff.

Applicable Laws and Regulations

Title 15, Code of Federal Regulations, Section 24.20 states, in part:

> (a) A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds. Fiscal control and accounting procedures of the State, as well as its subgrantees and cost-type contractors, must be sufficient to –
>
> (1) Permit preparation of reports required by this part and the statutes authorizing the grant, and
> (2) Permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.

Title 15, Code of Federal Regulations, Section 24.41 states, in part:

> 2) Accounting basis. Each grantee will report program outlays and program income on a cash or accrual basis as prescribed by the awarding agency.
>
> 4) Due date. When reports are required on a quarterly or semiannual basis, they will be due 30 days after the reporting period.

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-7

The Department of Health does not adequately monitor its subrecipients for the Breast and Cervical Cancer program.

Background

The Department of Health administers the federal Breast and Cervical Cancer Early Detection Program (CFDA 93.919) in Washington State. The program is designed to provide uninsured and underinsured women with breast and cervical cancer screenings and related services. Over 9,000 women are enrolled and screened annually.

The Department provides technical assistance and federal financial assistance to eight subrecipients, known as prime contractors, who administer the program in regions throughout the state. In turn, the prime contractors work with clinics, private physicians, hospitals, local health departments, laboratories, and radiology facilities that provide services to eligible clients. The group of eight prime contractors includes five local health departments, one hospital and two private, for-profit organizations.

Description of Condition

In fiscal year 2003, the Department reported grant expenditures of $5,071,956. About half of this amount is awarded to the eight prime contractors to carry out administrative responsibilities and to pay the providers for services rendered. During our audit, we reviewed the Department's system for monitoring the activities of its subrecipients and the method of paying subrecipient claims. The monthly claims include program administration costs and provider billings. We found that the prime contractors do not submit supporting documentation of their costs with reimbursement claims. We also reviewed the Department's procedures for reviewing financial documentation when it performs on-site visits of the eight contractors, which would provide a compensating control, but found that it does not review that information.

However, we did note that while the internal controls over the monitoring of contractor financial information need improvement, the Department provides a substantial amount of technical assistance to the contractors. The Department also has established procedures for the contractors to ensure that only eligible clients are served and that provider billings are allowable.

Cause of Condition

The Department was aware of the need to review financial information of its subrecipients, but lacked the staff to meet this responsibility.

Effect of Condition

Given the lack of documentation to support reimbursement claims and a lack of fiscal monitoring, the Department cannot ensure that its subrecipients have spent grant funds for allowable purposes.

Recommendations

We recommend the Department review the financial documentation that supports subrecipient reimbursement claims as part of its on-site monitoring program. Alternatively, the Department could require all subrecipients to submit supporting documentation with their reimbursement claims.

Department's Response

We concur with the finding by the State Auditor's Office. All community-based subrecipients submit electronic documentation for clinical costs monthly. All local health jurisdiction subrecipients submit electronic documentation for clinical costs monthly. Both community-based and local health jurisdictions will have financial documentation reviewed on site periodically, in conjunction with other department programs, and through a program review/quality assurance process that is under development.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issue identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Section .400(d), states in part:

> **Pass-through entity responsibilities**. A pass-through entity shall perform the following for the Federal awards it makes: …
>
> Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved….

03-8

The Department of Social and Health Services, Medical Assistance Administration, received federal Medicaid funds for unallowable services provided to undocumented aliens.

Background

As a requirement for receiving federal Medicaid funds (CFDA 93.778), the Department of Social and Health Services must provide medical benefits to otherwise eligible residents of the United States who are citizens, aliens lawfully admitted for permanent residence, and certain aliens who have been granted lawful temporary resident status. When medical services are rendered to undocumented aliens, federal matching funds are available only for emergency medical services, including obstetrical services that have been provided at the time of delivery. Emergency medical services are defined in the U.S. Code of Federal Regulations and the Medicaid State Plan. Non-emergency medical services provided to undocumented aliens cannot be charged to the federal government. The Department and the federal government defines "emergency medical condition" as the sudden onset of a medical condition so severe that without immediate medical attention, it would be expected that there would be serious jeopardy to a person's health; serious impairment of bodily functions, or a serious dysfunction of any bodily organ or part.

Description of Condition

From July 2002 through December 2002, Department records show that 9,717 undocumented alien clients received medical services. Of those served, we judgmentally selected 169 patients in six service categories to determine whether all Medicaid-funded services provided to these clients were emergencies as the law stipulates.

We found that non-emergency procedures, routine medical services and durable medical equipment were provided to undocumented aliens and paid for with Medicaid funds. We found payments for adult day health, massages, dental fillings, routine eye exams, regular office visits and in-home care, as well as supervision of normal pregnancies and routine postpartum follow-up. Medicaid payments were made for eyeglasses and contact lenses, breast pumps, dentures, contraceptive devices, disposable incontinence garments, and replacement wheels for wheelchairs. We found payments for conditions such as menopause, cough, breast engorgement, and nearsightedness.

The results of our review were as follows:

Service	Total Clients	Total Paid	Clients Receiving Unallowable Services	Questioned Costs (includes state and federal funds)
Nursing Home	42	$1,098,425.23	36	$977,156.64
Dental Services	62	$410,697.54	57	$138,493.09
In-Home Care	38	$399,335.95	36	$162,261.30
Adult Day Health	8	$84,381.85	8	$47,900.06
Community Inpatient	8	$48,368.93	2	$1,315.41
Personal Care	11	$28,284.29	9	$9,034.52
Totals	**169**	**$2,069,493.79**	**148**	**$1,336,161.02**

The Department initially stated that many of these services, especially those related to maternity, were paid for with state funds. To substantiate this, we traced the claims for routine dental care and other supportive care for two

undocumented alien maternity clients. Although we found coding that identified undocumented aliens, we were unable to find account coding that would differentiate between emergent and non-emergent procedures. Instead, we found all services were being claimed as allowable costs for Medicaid matching funds. Additionally, the Department could provide no evidence for its representation that services for routine pre-natal and post-natal maternity services were paid using state funds, that the services provided originated from an emergency condition or that related care provided to undocumented aliens months after an emergency condition is an allowable Medicaid expenditure under the law.

Cause of Condition

- Social security numbers are not consistently verified prior to admitting clients into the Medicaid program. The Department's client eligibility database shows social security numbers for many undocumented aliens. Further, the Department does not heed the federal alerts notifying staff of invalid social security numbers.

- In its eligibility manual, the Department lists certain medical diagnoses that are pre-authorized as an emergency. If a client who is an undocumented alien has a medical diagnosis that is not on the list, staff are instructed to refer the case to Department medical consultants. We found these referrals are not being made in a consistent manner.

- Department staff informed us the procedure manuals contain insufficient and unclear guidance and are often too technical for non-medical personnel to understand.

- Medical consultants are slow to respond to staff questions about whether a condition is an emergency.

- The Department's accounting system does not differentiate undocumented aliens who have received emergency services from those who have received non-emergency services.

Effect of Condition

Federal Medicaid funds are paying for non-emergency medical services for persons that are not eligible for Medicaid due to their undocumented alien status. We found 88 percent of the undocumented aliens tested were provided services for non-emergency conditions. The cost for these services was $1,336,161. Additional questioned costs related to the two maternity clients described above were $6,259. We are questioning the federal portion of the costs, which totals $671,210.

Recommendations

We recommend that the Department:

- Develop internal controls that would require employees to verify applicant's social security numbers and heed alerts sent by the Social Security Administration pertaining to invalid social security numbers.

- Develop clear policy and procedure manuals.

- Establish internal controls that ensure staff make consistent referrals to medical consultants for diagnoses that are not listed in the eligibility manual and ensure that consultants respond promptly.

- Develop an accounting system that would differentiate emergency from non-emergency procedures so that the appropriate funds could be used to pay for the designated services.

- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be returned.

Department's Response

The Department of Social and Health Services, Medical Assistance Administration, partially concurs with this finding.

First, DSHS would like to state that the State Auditors Office fails to recognize that there are legitimate reasons why State may be unable to obtain the correct SSN:

1. *Certain programs (e.g., AEM) do not require SSNs;*
2. *Food Assistance rules require DSHS to provide expedited benefits and this can prevent the Department from obtaining the SSN;*
3. *The Department apprises SSA that two different people have the same SSN; but SSA fails to correct the situation;*
4. *Sometimes a worker may suspect that the client is using an invalid SSN, but finds it necessary to enter it into ACES so it can cross-match with other systems for income data;*

Therefore, depending on the type of assistance or the need to expedite benefits, a SSN may not always be available. When Social security numbers are received they are entered into the system. DSHS does not wait for the application to be approved while verifying the social security number. When the social security number is entered into ACES it is verified in the interface. Currently the interface runs monthly.

With regard to the audit "cause of condition" items that refer to medical diagnosis and referrals, the procedure manuals and medical staff responses, DSHS staff need to review the cases tested by the State Auditors Office to determine which programs and services are being addressed and have been identified as being in error. Once DSHS has had an opportunity to review the cases tested by the State Auditors Office, it will then address each of the items/areas that have been identified as needing to be strengthened, if applicable.

The absence of services to a client who meets the functional criteria for nursing facility care and COPES services could reasonably be expected to result in:

- *placing the patient's health in serious jeopardy,*
- *serious impairment to bodily functions, or*
- *serious dysfunction of any bodily organ or part.*

If we do not provide services to these individuals, especially the nursing home clients, they will end up in the hospital with medical expenses at a much higher cost of care. CMS also defines nursing facilities as medical institutions.

Also, the Yakima Superior Court in Gutierrez v. DSHS, ruled against the Department and MAA's medical consultant and found that the law does not require successful and appropriate medical treatment for an emergency condition to then lose coverage because it keeps the individual in an improved medical condition. In other words, just because a client's emergency condition has stabilized, does not mean that the client loses eligibility. If the emergency condition continues, so does the medical eligibility.

Second, given these elements of the program, DSHS does not concur with the questioned cost of $671,210. Nursing home and COPES clients by nature of their functional assessment meet the emergency medical condition criteria

With regard to improving the current structure/system, the Department is taking several steps to improve accuracy of SSNs:

1. *ACES is convening a work group to review options to improve accuracy. This would include further automating how we query SSA systems.*
2. *Based on the above review, the Department will provide additional training to financial workers on how to improve accuracy of SSNs.*
3. *When the social security number is entered into ACES it is verified in the interface. Currently the interface runs monthly, it will be changed to daily process.*

The Department will also be reviewing the coding used to identify emergent and non-emergent procedures for areas of improvement and its procedure manuals for easy of use.

Auditor's Concluding Remarks

The federal statutes are clear that an individual must have a valid social security number in order to be eligible for Medicaid benefits. The reasons offered by the Department as to why it has not ensured adequate controls do not reverse federally mandated requirements. Our position in response to the Department's reasoning is as follows:

- Programs such as Alien Emergency Medical do not negate the Department's obligation to ensure the validity of the social security number for citizens applying for Medicaid.

- Federal food assistance programs are not linked to Medicaid and thus the eligibility rules for these are not applicable to the Medicaid program.

- The Department stated it informs the Social Security Administration of two persons having the same social security number. In our audit, we have never encountered this situation nor had the Department brought this condition to our attention at the time of our fieldwork.

- When staff suspects that a client is using an invalid social security number, we have found in most cases that the Medicaid application is approved and benefits are immediately given. Our audit revealed that Department computer systems have received up to five social security numbers for some of its clients. In the cases that we have reviewed, the Department has never attempted to obtain the correct social security number.

As noted in the finding, Department staff are able to ensure the validity of each applicant's social security number using the State On-Line Query (SOLQ). SOLQ is a database provided by the federal government of which one of its purposes is to verify social security numbers. In the Community Service Offices that we visited this year, we found that staff rarely use SOLQ to verify an applicant's social security number at the time of application. This is true for the application process at headquarters, as well. Management is aware that this control is consistently bypassed.

The federal statute is explicit in its definition of emergent. For undocumented alien clients, the federal statute is also clear that only emergent services are eligible for federal financial participation. The expectation that a condition may eventually become emergent in the absence of routine or rehabilitative medical services is not a component of the criteria. Additionally, the federal statute does not contain a provision that deems conditions that meet the "functional" criteria for nursing home care and in-home care as equivalent to emergent conditions.

With respect to Gutierrez v. DSHS, the State Auditor's Office takes no position as to what care or how much care the state should render to its undocumented alien clients. However, the federal government has stipulated that, for this population, it will only provide federal financial participation for conditions that are emergent. Therefore, if the State wishes to provide routine and rehabilitative care to its undocumented alien clients, it should do so using only state funds. Utilizing federal funds for these activities may be viewed by the U.S. Department of Health and Human Services as a disregard for federal statutes, which may jeopardize future federal funding or which may result in increased federal scrutiny for Washington's Medicaid program.

Applicable Laws and Regulations

Title 42, Code of Federal Regulations, Section 435.404(a)(4)(b) provides the following guidance:

> The agency must only provide emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act), and services for pregnant women as defined in section 1916(a)(2)(B) of the Social Security Act to otherwise eligible residents of the United States not described in paragraph (a)(3) and (a)(4) of this section who have been granted lawful temporary or lawful permanent resident status...

Section 1916(2)(D) of the Social Security Act provides that emergency services are defined by the Secretary:

> ...the State plan shall provide that in the case of individuals... who are eligible under the plan...(2)

> no deduction , cost sharing or similar charge will be imposed under the (State) plan with respect to ...(D) emergency services (as defined by the Secretary)...

Emergency services as described by the Secretary are as follows in Washington Administrative Code 388-500-0005:

> Emergency medical condition means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> Placing the patient's health in serious jeopardy;
> Serious impairment to bodily functions; or
> Serious dysfunction of any bodily organ or part.

Washington Administrative Code 388-500-0005 defines emergency medical expense requirements as follows:

> A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

The Department's *A-Z Eligibility Manual* describes what constitutes an emergency medical condition. It states, in part:

> 1. ...In order to be eligible for the Alien Emergency Medical (AEM) program, a person must:…a. Have an emergency medical condition. (Refer to the list of emergency medical condition in the Medically Indigent section); ...

Washington Administrative Code 388-438-0110 describes alien emergency medical as follows:

> An alien who is not eligible for other medical programs, is eligible for emergency medical care and services:
>
> (1) regardless of their date of arrival in the United States;
> (2) Except for citizenship, meets Medicaid eligibility requirements as described in Washington Administrative Code 388-505-0210, 388-505-0220 or Washington Administrative Code 388-505-0110; and
> (3) Limited to the necessary treatment of an alien's emergency medical condition as defined in Washington Administrative Code 388-500-0005, except that organ transplants and related medical care services are not covered.

Washington Administrative Code 388-424-0010 describes alien status and eligibility requirements for medical benefits. Paragraph (3) states the extent of those services:

> An alien who would qualify for Medicaid benefits but is ineligible solely because of his or her alien status, can receive medical coverage as follows:
>
> (a) State-funded categorically needy (CN) scope of care for …(i) Pregnant women, as specified in Washington Administrative Code 388-462-0015

Washington Administrative Code 388-462-0015 states that care to pregnant women who do not meet eligibility requirements due to citizenship status will be provided under state funded programs solely:

> A pregnant woman is eligible for CN scope of care under the state-funded pregnant woman program if she is not eligible for programs in subsection (2) of this section due to citizenship, immigrant or Social Security Number requirements.

Revised Code of Washington 43.20A.550 states that rules and regulations that are in conflict with federal law are deemed inoperative:

> … Any section or provision of law dealing with the department which may be susceptible to more

than one construction shall be interpreted in favor of the construction most likely to comply with federal laws entitling this state to receive federal funds for the various programs of the department. If any law dealing with the department is ruled to be in conflict with federal requirements which are a prescribed condition of the allocation of federal funds to the state, or to any departments or agencies thereof, such conflicting part of chapter 18, Laws of 1970 ex.sess is declared to be inoperative solely to the extent of the conflict.

03-9

The Department of Social and Health Services, Medical Assistance Administration, has not established sufficient internal controls to ensure that Medicaid payments are made only to persons with valid social security numbers and are not made on behalf of deceased individuals or persons using the social security numbers of deceased individuals.

Background

The Department of Social and Health Services is responsible for administering the state of Washington's Title XIX Medicaid program (CFDA 93.778), which receives nearly $3 billion in federal funds annually. Medicaid expenditures include medical assistance payments for eligible recipients for services such as hospitalization, prescription drugs, nursing home stays, outpatient hospital care and physician services. Eligibility for Medicaid is based on many factors; however, a valid social security number is required in most cases for an individual to be eligible for Medicaid. This is true for children as well.

Description of Condition

During our 2002 audit, we analyzed the validity of Medicaid clients' social security numbers as well as claims that could have been paid on behalf of a person who had died. During that audit, we sampled 639 Medicaid recipients and found that 50 percent had exceptions related to the validity of the client's social security number. For example, we identified invalid social security numbers, Medicaid payments for services rendered after individuals had died, and clients who were using a social security number that was assigned to a deceased person. Factors contributing to these conditions included Department staff not heeding or investigating alerts sent by the Social Security Administration; the Department's reliance on family members to voluntarily inform it of a client's death; and computer errors that occurred when client data was being transmitted between the Department's client eligibility system and the Medical Management Information System.

During our current 2003 audit, we attempted to determine if the Department had established controls that would ensure that only claimants with valid social security numbers were enrolled in the program and that people who were deceased were promptly removed from Medicaid eligibility. We have found that the Department does not have effective procedures that are universally applied that would enable all the Community Service Offices to be notified of a client's death in a consistent and timely manner. Additionally, the Department and the Department of Health do not communicate for the purpose of obtaining notice of client deaths.

We also found that the internal controls that would ensure the validity of social security numbers were inconsistent from one Community Service Offices to another. We reviewed the controls at 11 Community Service Offices and found the following weaknesses:

- Sixty-four percent of the offices we visited were not verifying social security numbers at time of application.
- Eighteen percent did not provide training to staff in the use of the tools that would assist in determining the validity of a client's social security number.
- One hundred percent of the offices have no system in place to inform management of the social security number alerts that have existed or currently exist.
- One hundred percent of the offices have no mechanism to prevent the deletion of an alert by staff without management's knowledge.
- Twenty-six percent of the offices have no management oversight of the alerts sent by Social Security Administration.

As part of our audit, we also reviewed Medicaid funds paid through the Department's Social Service Payment System. We selected 29 individuals who appeared to have been provided services after their dates of death. We found that providers for eight of these clients received payments for services they reported to have provided after the

individual's death. Medicaid payments in these instances amounted to $73,415 of which $20,463 remained yet to be recouped or resolved as of June 30, 2003.

Cause of Condition

- The Department is largely dependent on the provider or the family to report a client's death.
- Alerts sent by the federal government informing the Department of a client's death are not heeded in a timely fashion or are overridden by staff. Additionally, workers are able to clear alerts without management's knowledge and there is no monitoring by management of the status of alerts issued.
- There are known computer problems with the transfer of some data from the Automated Client Eligibility System to the Medical Management Information System.
- The Department has the capability of verifying the validity of a social security number with the State On-Line Query (SOLQ) at the time of application. This control is not always used by staff largely because they are not consistently and timely trained in the use of SOLQ.
- There is no system of communication between the Department and the Department of Health that would alert the Department of the clients who have died.

Effect of Condition

In order to be eligible to receive Medicaid, an individual must have a valid social security number or must have applied for a number. Each claim paid on behalf of a client with an invalid social security number is an unallowable cost. Also, the Department's inability to identify deceased clients in a timely manner allows providers to continue to submit claims on behalf of people that are deceased without timely detection.

In addition to evaluating the internal controls over social security numbers in the Department's Medical Management Information System, we reviewed claims paid through the Department's Social Service Payment System. Of the 29 clients selected, we found eight for whom Medicaid funds were paid for services rendered after the client was deceased. As a result, we are questioning $10,232 in federal funds related to these claims.

Recommendations

We recommend the Department develop and follow procedures that:

- Require staff to verify social security numbers for all Medicaid clients.
- Require staff to heed alerts sent by the Social Security Administration.
- Make it impossible for staff to delete alerts without management's approval and/or knowledge.
- Resolve the computer interface problems between the Automated Client Eligibility System and Medical Management Information System.
- Establish a system with the Department of Health that will provide notification of clients' deaths in a timely manner.

We also recommend the Department work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be reimbursed.

In addition, in its implementation of controls to ensure the validity of social security numbers, we recommend the Department consider the state identity theft law, Revised Code of Washington 9.35.020, that takes effect July 1, 2004.

Department's Response

The Department of Social and Health Services, Medical Assistance Administration, partially concurs with this finding.

There are valid reasons why States may be unable to obtain or verify the correct SSN:

1. *Certain programs (e.g., AEM) do not require SSNs;*
2. *Food Assistance rules require DSHS to provide expedited benefits and this can prevent the Department from obtaining the SSN;*
3. *The Department apprises SSA that two different people have the same SSN; but SSA fails to correct the situation;*
4. *Sometimes a worker may suspect that the client is using an invalid SSN, but finds it necessary to enter it into ACES so it can cross-match with other systems for income data;*

Therefore, depending on the type of assistance or the need to expedite benefits, verification of SSNs is not an eligibility factor for assistance programs.

With regard to improving the current structure and internal controls, the Department is taking several steps to improve accuracy of SSNs for both living and deceased individuals:

1. *ACES is convening a work group to review options to improve accuracy. This would include further automating how we query SSA systems,*
2. *DSHS will conduct a review of current procedures with regard to reviewing SSNs for validity and identify areas that could be strengthened;*
3. *Based on the above reviews, the Department will provide additional training to financial workers on how to improve accuracy of SSNs.*
4. *When the social security number is entered into ACES it is verified in the interface. Currently the interface runs monthly, it will be changed to daily process.*
5. *The recommendation to resolve the interface problems between ACES and MMIS has already been addressed. The Department has modified the ACES-MMIS interface in July 2003.*

The Department has reviewed the transactions tested by the State Auditors Office and concurs with the questioned costs identified in the amount of $10,232.00.

Auditor's Concluding Remarks

The federal statutes are clear that an individual must have a valid social security number in order to be eligible for Medicaid benefits. The reasons offered by the Department as to why it has not ensured adequate controls do not reverse federally mandated requirements. Our position in response to the Department's reasoning is as follows:

- Programs such as Alien Emergency Medical do not negate the Department's obligation to ensure the validity of the social security number for citizens applying for Medicaid.

- Federal food assistance programs are not linked to Medicaid and thus the eligibility rules for these are not applicable to the Medicaid program.

- The Department stated it informs the Social Security Administration of two persons having the same social security number. In our audit, we have never encountered this situation nor had the Department brought this condition to our attention at the time of our fieldwork.

- When staff suspects that a client is using an invalid SSN, we have found in the majority of cases that the Medicaid application is approved and benefits are immediately given. Our audit revealed that Department computer systems have received up to five social security numbers for some of its clients. In the cases that we have reviewed, the Department has never attempted to obtain the correct social security number.

As noted in the finding, Department staff are able to ensure the validity of each applicant's social security number using the State On-Line Query (SOLQ). SOLQ is a database provided by the federal government of which one of its purposes is to verify social security numbers. In the Community Service Offices that we visited this year, we found that staff rarely use SOLQ to verify an applicant's social security number at the time of application. This is true for the application process at headquarters, as well. Management is aware that this control is consistently bypassed.

Applicable Laws and Regulations

The Code of Federal Regulations is precise in its directives regarding obtaining and verifying social security numbers as a condition of eligibility for Medicaid determination. Title 42, Code of Federal Regulations, Section 435.910(a) specifically states, pertaining to eligibility, the following:

> The agency must require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSNs)…

Regarding the agency's responsibility for the verification of SSNs, Title 42, Code of Federal Regulations, Section 435.910(g) states:

> The agency must verify each SSN of each applicant and recipient with SSA, as prescribed by the commissioner, to insure that each SSN furnished was issued to that individual and to determine whether any others were issued.

Title 42, Code of Federal Regulations, Section 435.910 states:

> …(e) If an applicant cannot recall his SSN or SSNs or has not been issued a SSN the agency must--
>
> (1) Assist the applicant in completing an application for an SSN;
> (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
> (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.
>
> (f) The agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA.

For the redetermination of Medicaid eligibility and social security numbers, Title 42, Code of Federal Regulations, Section 435.916(a) states:

> The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months….

Title 42, Code of Federal Regulations, Section 435.920 (a)-(c) states:

> (a) In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN.
> (b) If the case record does not contain the required SSNs, the agency must require the recipient to furnish them and meet other requirements of 435.910.

If the agency initially established eligibility without verification of the SSN, Title 42, Code of Federal Regulations, Section 435.920(c) requires:

> For any recipient whose SSN was established as part of the case record without evidence required under the SSA regulations as to age, citizenship, alien status, or true identity, the agency must obtain verification of these factors in accordance with 435.910.

The Medicaid State Plan identifies the above references as being applicable to Washington State's coverage and eligibility criteria when it states the following:

> The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.
>
> [*Subpart J of the CFR encompasses all citations from subsection 435.900 through 965 and thus would include the regulations cited above.*]

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-10

The Department of Social and Health Services, Medical Assistance Administration, did not provide the State Auditor's Office reliable records needed for audit in a timely manner.

Background

The Department of Social and Health Services is responsible for administering the state of Washington Title XIX Medicaid program (CFDA 93.778), which receives nearly $3 billion in federal funds annually. Most of the state's Medicaid claims are processed through the Medical Management Information System (MMIS). The Department contracts with a vendor for certain services relating to MMIS. These services include facility management services, operation, records retention, data security and keeping all system files, programs and documentation current.

Description of Condition

The Department acquired data from MMIS for the period July 1, 2002 through December 31, 2002 from the vendor on April 2, 2003. This data was to be used during our Medicaid audit. Specifically, we planned to determine the number of prescription drug claims that were paid for services rendered after a person's death. This was to be a follow-up up on issues identified in our 2002 audit. Our 2002 audit revealed, among other things, that the majority of claims submitted for services rendered after death were for prescription medications.

We obtained a valid sample pursuant to the American Institute of Certified Public Accountants Statement on Auditing Standards No. 39. We selected 210 clients out of 10,809 who were provided prescription medicine services and found 148 potential exceptions with related questioned costs of $10,277,374. Fifty percent of these costs were paid with federal Medicaid funds.

After we presented our preliminary results to the Department, it informed us that we had been given inaccurate data that contained mismatched names and social security numbers. We estimated these errors affected at least 30 percent of the population. Approximately four months later, the Department confirmed that the data errors were caused by the vendor and gave us a new set of data.

After receiving the new data, we evaluated the explanation sent by the Department's vendor and performed some comparative testing on the original and new data sets to determine whether we could rely on the Department's explanation and whether we could rely on our preliminary audit results. Initially, we did not find any differences in the total number of records or total amounts of claims paid. However, a more detailed analysis revealed the data sets were different for social security number, date of birth, and name matches. We concluded that we could not rely on the original data because our sample was based on social security numbers.

While analyzing the two data sets, we found inconsistencies in the Department's explanation for the mismatch:

- Many of the social security numbers that Medical Assistance Administration stated should have been matched to a name were not in the original data set.

- The vendor who performed the data collection for Medical Assistance claimed that the mismatch was due to an incorrect Patient Identifier Code matched to the wrong social security number. We did not see the mismatch for all clients.

- Medical Assistance claimed that 32 percent of the Patient Identifier Codes were mismatched, yet its own spreadsheet detailing the purported errors in our testing attributable to the mismatches showed an error rate of approximately 85 percent.

- Medical Assistance claimed that the individuals that we initially questioned had valid social security numbers and were not deceased. However, as described in finding 03-9 of this report, we noted that internal controls over social security numbers were not much improved from our 2002 audit.

The purpose of our sample was to test prescription drug claims to determine whether claims were paid for services rendered after a client's death. The universe of all MMIS transactions from July 7, 2002 through December 31, 2002 was the same for both data sets: 17,379,976 records for a total amount of $1,537,429,678.72.

From the universe, all records for prescription drugs were extracted. A comparison revealed the following differences:

New Data:
Total number of records for all prescriptions (fill date section not blank): 5,783,093
Total paid amount for all these records is $288,498,037.77

Original Data:
Total number of records for all prescriptions (fill date section not blank): 5,792,060
Total paid amount for all these records is $291,004,403.55

Because of the differences, we could not be assured that we had obtained all the data pertaining to prescription drug claims. In addition, we could not identify the specific cause of the differences due to the inconsistencies in the Department's explanation. As a result, we did not continue our analysis of the two data sets and concluded we should disclaim our opinion on compliance.

Cause and Effect of Condition

The Department provided the State Auditor's Office with data that contained errors and mismatches. Therefore, we are disclaiming our opinion on compliance as it relates to allowable costs and eligibility of clients for whom prescription drug claims were charged to the federal government for the period July 2002 through December 2002. The payments attributable to prescription drug claims could not be determined, but is at least $288,498,038. The necessity of this disclaimer is due to a client imposed scope limitation and is based on the following facts:

- We could place no reasonable assurance that the results of our sample using the original data were accurate.

- The Department did not take timely action to notify us of the faulty data. Thus, when a new data set was provided, we lacked adequate time and resources to complete our audit.

Recommendations

We recommend that the Department establish monitoring procedures that would enable it to supervise the performance of its MMIS vendor with more scrutiny. The system processes millions of claims annually. The proper disposition of these claims and the federal reimbursement received by the state is predicated, in large part, on the effective operation of the MMIS system and performance of the vendor.

Department's Response

The Department of Social and Health Services, MAA, concurs with and accepts responsibility for the delivery of the erroneous data to the SAO. Since the data was manipulated by SAO and the data file of SAO exceptions contained additional data from the Social Security Administration's Death Index, it was difficult for MAA to immediately determine the reasons for the discrepancies and identify the source of the error. This condition impacted the length of time that it took for the Department to discover the error. Upon discovery, the error was immediately communicated to SAO.

DSHS has implemented the following contract/vendor and internal control procedures as corrective actions to address these issues:

- *The contract management plan with the MMIS vendor ACS will be amended to strengthen the quality assurance requirements regarding reporting and data analysis activities and to assure that datasets produced by ACS are complete and reliable;*
- *The MAA Information Services Division has implemented processes for the review and retention of datasets requested by entities outside of MAA. MAA analysts now have the ability to load and review large data sets and MAA is developing and implementing a set of protocols that will govern the internal review of data prior to distribution.*

While DSHS accepts responsibility for the delivery of erroneous data, it should be noted that DSHS provided SAO with the following documentation, which provided evidence that the pharmacy claims were paid for clients who were not deceased:

- *A technical explanation of the error was provided by the MMIS vendor, ACS;*
- *A detailed review of the claims and clients in question and provided SAO with documentation regarding the status of each client on the exception list;*
- *The State Online Query (SOLQ) was utilized to verify Social Security numbers for clients as listed in the MMIS.*

For claims where exceptions correctly identified claims paid for deceased clients, claims were reviewed and action taken consistent with MAA policy.

Auditor's Concluding Remarks

We appreciate the Department taking responsibility for the delivery of erroneous data to our Office. However, we do not agree with the Department's statement that the data was manipulated by the State Auditor's Office, which caused the Department's delay in notifying us of the faulty data set. In its response, the Department stated it provided our Office with evidence that the pharmacy claims were paid for clients who were not deceased. Because we are disclaiming our opinion, we did not audit this information and cannot validate the Department's claim. The Department should provide this information to the U.S. Department of Health and Human Services (HHS) as part of the audit resolution process. However, we would offer to HHS:

- A technical explanation as to the reasons why the data set was faulty does not prove that no claims were paid after the date of death.

- The "detailed review" that the Department stated it provided was a spreadsheet of its representations. The Department provided no additional supporting documentation to corroborate its claims that a client was alive at the time services were rendered.

- Verification of a social security number can be performed on a deceased person as well as on one that is alive. Verifying a social security number does not prove that a person was alive at the time that medical services were rendered.

Applicable Laws and Regulations

American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraph 10.43 and 10.44 states, in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit – whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records – may require auditors to qualify their opinion or to disclaim an opinion.
>
> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

03-11

The Department of Social and Health Services, Medical Assistance Administration, has not established sufficient internal controls to ensure financial reports submitted to the federal government comply with Medicaid provisions.

Background

The Department of Social and Health Services administers the state of Washington Medicaid program (CFDA 93.778), which receives nearly $3 billion annually. These funds are used to pay medical providers for health care services for certain low-income people. The Department is required to report its expenditures for medical assistance and administrative costs to the federal government on a quarterly basis. In turn, the federal government reimburses the Department for its expenditures based on the information submitted on its reports. The report is referred to as the CMS-64.

Description of Condition

We reviewed the Department's procedures for preparing its quarterly reports and reviewed certain types of information to determine if it was accurately reported. We found the following reportable internal control weaknesses and reporting errors:

1. The Department is not reporting disbursements for alien emergency medical services.

   Between July 2002 and December 2002, the Department completed 438,921 transactions for a total of $41,748,835 in services for 9,717 undocumented aliens. Line 27 of the CMS-64, Emergency Services Undocumented Aliens, is to be used to report the allowable emergency expenditures for which the Department is seeking reimbursement from the federal government. However, the Department does not use this line. Instead, it combines payments for both emergency and non-emergency services and reports this amount on a different line.

   Cause of Condition

   The Department has no coding in its accounting records to differentiate emergency services from non-emergency services for undocumented aliens. As such, services are included as one accounting category.

   Effect of Condition

   Payments for ineligible services to undocumented aliens are reported by the Department as allowable expenditures. As a result, the Department is receiving federal Medicaid funds to which it is not entitled. Because emergency and non-emergency payments are commingled in the accounting records, the Department cannot determine the total amount of over-payments it has received.

   Recommendation

   We recommend the Department develop account coding that would differentiate emergency from non-emergency services for undocumented aliens and report the proper allowable amount on the correct line of the CMS-64.

2. The Department is underreporting disbursements in some categories.

   We reviewed the line designated as Other Care Services for the Medical Assistance Administration on the CMS-64 for the fourth quarter of federal fiscal year 2002. Included in the total amount reported on this line was $4,267,195 labeled as "suspense". The Department informed us the suspense account is used as a repository for all payments for which the Medical Management Information System (MMIS) does not recognize the coding. Such coding can occur in many situations, including the addition of new service codes or the addition of new clients. The System views these as errors and places the payment records in suspense rather than in the correct payment categories. The Department performs no adjusting entries to place these suspense transactions in the proper category of medical assistance payments.

Cause of Condition

Given staff shortages, the Department considers updating the System to be of lower priority than other responsibilities. However, it informed us that it has recently initiated steps to correct some of these problems.

Effect of Condition

Erroneous reports do not provide the grantor with complete information regarding how the Department has used its federal funding.

Recommendation

We recommend the Department establish procedures, including System updating and adjusting entries, to help ensure amounts initially reported on the Suspense line are properly moved to the appropriate payment category on the CMS-64.

3. The Department does not have sufficient internal controls over preparation of the CMS-64.

The Department does not reconcile the CMS-64 to its financial reporting system or to its cost allocation system. Additionally, we found the Department provides for no monitoring over the preparation of the claims before they are submitted. As such, the accuracy of the claims are not ensured. While the Department does have a representative from the federal government review reports and some transactions related to the claims, this review is a high level analytical review of disbursements. The federal representative does not certify or attest to the accuracy of the claim, which is the responsibility of the Department.

Cause of Condition

Reconciliations were performed in the past, but this control has stopped due to staff turnover and a lack of training and monitoring.

Effect of Condition

The lack of reconciliation and monitoring increases the risk that the Department's claims for reimbursement are inaccurate.

Recommendations

We recommend that the Department:

- Institute training protocols and monitoring procedures that would ensure accuracy in the preparation of the CMS-64.
- Perform reconciliations between the CMS-64 and the financial reporting and cost allocation systems prior to submission of each claim.

4. Payments for Disproportionate Share Hospitals were not accurately reported on the CMS-64 for the fourth quarter of federal fiscal year 2001.

Due to changes to MMIS that took effect on July 1, 2001, an error caused the System to miscode payments for Disproportionate Share Hospitals. The problem was not discovered until the CMS-64 had already been submitted to the federal government for the quarter ending September 30, 2001. In March 2002, while preparing its next quarterly report, the Department found the error, identified the cause, and began to correct the problem. The Medical Assistance Administration was aware of the problem, but did not notify the Department's Office of Accounting Services until May 2002. Proper adjustment and disclosure of the

error were not made until October 2002 because Accounting Services could not obtain all of the information it needed from Medical Assistance.

Cause of Condition

The Department stated that coding errors and a lack of communication between the Department's Office of Accounting Services and Medical Assistance Administration were responsible for the errors.

Effect of Condition

The lack of communication caused Office of Accounting Services to submit a report that was understated for Disproportionate Share Hospital payments by $4,700,549. This error was corrected one year later in the report submitted for the quarter ending September 30, 2002.

Recommendations

We recommend that the Department:

- Establish timely and consistent communications between Medical Assistance Administration and the Office of Accounting Services.

- Ensure that the coding in the Medical Management Information System is accurate.

Department's Response

The Department partially concurs with this finding. Each element of the finding will be addressed separately:

1. *Alien Emergency Medical Services – The Department does not concur with the element of the finding. MAA completed its review of the claims and has concluded that the clients on this list were eligible for the AEM services. With the decision from Gutierrez v. DSHS, Yakima Superior No. 032017662 (2003) and MAA policy, follow-up medical service to an emergency medical condition is claimable and coverable under the AEM program. Furthermore, it's impossible to determine, based on the procedure codes alone, whether the medical service provided was necessary to continue treatment of an emergency medical condition or to prevent the condition from imminently deteriorating to an emergency. In addition, many of the claims we reviewed were for pregnant women for which the AEM program pays for both labor and delivery. It is important to note that any non-emergent prenatal care provided to these women was charged to state only funds*

2. *Underreporting of Disbursements – The Department partially concurs with this element of the finding. The Department is not underreporting expenditures in aggregate, but because of a current situation in the MMIS system, there are expenditures included on Line 29, "Other Care Services" that should be reported elsewhere. All reported expenditures are for eligible Title XIX clients. There are certain instances where MMIS may not recognize the service code of a disbursement. These disbursements are assigned a code that currently has a misleading title of "Suspense". These are not suspense items. They are legitimate Title XIX disbursements and are reported on the CMS 64. This situation was identified by MAA prior to the audit and we are actively working on a solution.*

3. *Preparation of the CMS-64 – The Department does not concur with this element of the finding. The entire claim preparation is in itself a reconciliation of Title XIX expenditures. The CMS 64 claim system is a database that was created specifically to prepare the CMS 64 claim. On a monthly basis we reconcile the data that is imported to the claim system to ensure it matches the expenditures recorded in AFRS for the month. This allows us to begin the quarterly claim preparation with the exact expenditures that were recorded in AFRS for the quarter. During the preparation of the claim there are many steps taken that would legitimately cause the claimed amount to differ from the actual expenditures for the quarter. We created a document that summarizes the reconciliation differences. Although we did not use this summary document for several claim quarters it does not improve or take away from the reconciliation of expenditures claimed on the CMS 64 to AFRS.*

   Additionally, the Department does not agree with the statement that DSHS "…provides for no monitoring over

the preparation of the claims…". CMS has a full time fiscal auditor assigned to the State of Washington who is on-site at DSHS for several weeks during the preparation of the claim. The CMS auditor reviews cost categories and expenditure detail during the preparation of the claim, requesting justification and explanation for specific expenditures. The auditor approves the claim submission prior to DSHS certifying the claim.

4. *DSH Payments – The Department concurs with this element of the finding. There is now better coordination between staffs in the Office of Accounting Services and Medical Assistance Administration. Additionally, the Medical Assistance Administration staffs have implemented better tracking and monitoring mechanisms for these payments. To be provided*

Auditor's Concluding Remarks

Condition 1: The Department is not reporting disbursements for alien emergency medical services.

The Department should develop controls that would make it possible to determine whether the medical service provided was for emergency or non-emergency conditions. It is this condition that is causing the commingling of unallowable services with allowable services on the federal reporting form. During our audit, the Department provided no evidence that the non-emergency services rendered were originally related to an emergent condition. Further, federal statutes have no provisions for federal financial participation for routine or for follow-up services related to emergency conditions.

Some of the clients that we reviewed were maternity clients. However, the medical procedures we took exception to were for services completely unrelated to the labor and delivery process. Examples of some of the unallowable services include routine dental exams, dental fillings, contact lenses, massages and breast pumps.

Our audit revealed that non-emergency prenatal care was paid for with federal funds and not state funds as the Department asserts. We ascertained this by tracing the services rendered from the provider's claim to the federal report (CMS-64) on which the Department lists the services eligible for federal funding.

Condition 2: The Department is underreporting disbursements in some categories.

Our primary concern in this area is not the allowability of the charges, but whether or not the services are being properly reported on the correct lines of the CMS-64. This will ensure that the federal government receives the most accurate information from which it can make decisions about the program. The Department is performing no adjusting entries that would make the report accurate.

Condition 3: The Department does not have sufficient internal controls over preparation of the CMS-64.

The internal controls that the Department employed over the preparation of the CMS-64 during our audit period appeared significantly weaker than we have seen in past years. During our fieldwork, staff indicated no reconciliations were being performed. The errors and other reportable conditions that we have found in the CMS-64 during our audit substantiates our position that Departmental monitoring could be improved.

Applicable Laws and Regulations

The state of Washington's Office of Financial Management's *State Administrative and Accounting Manual* Section 50.30.45.2, describes the reporting responsibilities of state agencies that administer or expend federal awards:

> Identity, account for, and report all expenditures of federal awards in accordance with laws, regulations, contract and grant agreements, and requirements included in this and other sections of the OFM *State Administrative and Accounting Manual***.**

Title 45, Code of Federal Regulations, Section 92.20(a), states:

> A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

Title 42, Code of Federal Regulations, Section 430.30(c) states:

> Expenditure reports. (1) The State must submit Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to the central office (with a copy to the regional office) not later than 30 days after the end of each quarter. (2) This report is the State's accounting of actual recorded expenditures. The disposition of Federal funds may not be reported on the basis of estimates.

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-12

The Department of Social and Health Services, Medical Assistance Administration, has not established sufficient internal controls to ensure the eligibility of families enrolled in the Medicaid Basic Health Plus program.

Background

Basic Health Plus (BHP) is a Medicaid program (CFDA 93.778) for children of low-income households. BHP members pay no monthly premiums or co-payments. The Department, with federal participation, pays the entire cost of coverage. Our 2001 audit revealed multiple weaknesses in the internal controls over client eligibility:

- The Department did not require the annual re-certification form to be returned unless the parent/guardian's income changed. It assumed no income change if the form was not returned.
- The Department performed an inadequate number of re-certification reviews to determine compliance with eligibility requirements.
- When it did perform re-certification reviews, the Department did not require proof of income.
- The Department did not ensure that clients were within the program's income limits upon application.

In 2001, we judgmentally selected 60 clients and found that 27 did not meet the net income standards for Medicaid eligibility, which is a 45 percent exception rate.

In our 2002 audit, we found that the Department was in the process of restructuring controls and training staff. However, the majority of corrective actions did not occur before fiscal year 2002 had ended and the internal control weaknesses that were found in 2001 continued in 2002. Thus, a repeat internal control finding was reported in 2002.

Description of Condition

During our current audit, we reviewed the actions taken by the Department to address these weaknesses and found it had made some significant improvements. Most notable among these was the Job Operating Instruction Manual that the Department has developed to assist staff in transitioning to the new income verification requirements. Furthermore, the State's 2003-2004 supplemental budget included provisions requiring the Department to verify household income for individuals receiving medical benefits under Family and Children's Medical, to review eligibility every six months and to require parents/guardians to report household income changes immediately.

The majority of these corrective actions, however, were not taken before fiscal year 2003 ended. Despite the changes that were made, weaknesses continue. These include:

- For self-employed households, income information is not corroborated with an independent source such as tax returns from the state's Department of Revenue or the Internal Revenue Service. Although the Department requires receipts for expenses, for self-employed clients the Department continues to accept a self-declaration of income.
- Although income changes must be reported immediately, the Department could not provide evidence of procedures that ensure that this is occurring in a consistent manner.
- Department eligibility review quotas have not been achieved.

In addition, the state Health Care Authority informed us it sends the Department a monthly report of subscribers that are being dis-enrolled due to noncompliance with the Authority's recertification process. The Department is not using these reports as a control.

Also, as part of our follow-up work, we reviewed five wage-earning clients and five self-employed clients. We found that three of the wage-earning clients and all five of the self-employed clients were either currently ineligible for benefits or the Department could not provide the documentation to substantiate their initial eligibility.

Cause of Condition

- The Department has not completed its corrective action plan.
- The Department has not addressed remaining internal control weaknesses.
- The Department reports that eligibility review quotas have not been achieved because of heavy caseloads and a lack of staff.

Effect of Condition

The Department is not complying with requirements that it make Medicaid payments only for eligible clients. As a result, we question $17,118, of which $8,559 was paid in federal funds for eight families who did not meet the income requirements.

Recommendations

We recommend the Department:

- Establish controls for weaknesses that have not yet been addressed.
- Provide adequate resources so that sufficient monitoring can be achieved.
- Work with the U.S. Department of Health and Human Services to determine if any unallowable costs charged to Medicaid must be reimbursed.

Department's Response

The Department partially concurs with this finding. DSHS does not concur with the part of finding regarding internal controls and we reaffirm our prior years audit response with additional clarification to statements made in this audit finding regarding internal controls:

Internal Controls:

- *MEDS does work with HCA on reported income changes during the certification period and is followed up at annual review time. It is an expectation for both Basic Health (BH) and Medical Assistance Administration (MAA) staff to follow Chapter 5, section 5-02 Basic Health Plus Pregnancy Medical Change of Circumstances – Change in Household/Income in the BH/MAA Policy and Procedure Manual.*
- *There is not a requirement to verify income unless it is questionable. Self-declaration of household circumstances is provided under MAA's policy distributed to the field on December 3, 1998. DSHS is notified of household income by BH.*
- *MEDS follows established DSHS policies for corroborating client income as outlined in the Eligibility A-Z Manual, WAC 388-406-0030 (3); WAC 388-490-0005 (2), (3), (4), (5) (a), (b), (c), (8) (a), (9), (10); WAC 388-458-0001. Income can be verified via pay stubs, statement from employer, SEMS data, bank statements, collateral contact, SOLQ. These procedures are already established and staff follows them in order to corroborate a client's income declaration if necessary.*
- *MEDS has always corroborated a client's income declaration if the declared income is at or above 200% FPL, by pending the application or review and requesting proof of income.*
- *Changes in income do not affect a child's Medicaid eligibility during their certification period.*

The Department does concur that case auditing for Basic Health Plus was not in compliance with our internal corrective action plan governing Adequate Resources. We will update the plan to ensure additional oversight of the existing corrective action plan. It is important to clarify that this relates to case auditing by MEDS lead workers

and supervisors. The audit plan was developed without any advance knowledge Department policies would be changing, or they would lose staff, which required their leads to carry caseloads, while training new staff at the same time. This is not an excuse, but reality. Due to these unanticipated workload impacts, the auditing was reduced because we had new client service.

The Department will contact CMS, as we did due to the previous audit findings, to verify treatment of questioned Medicaid dollars with regard to eligibility.

The Department does appreciate the auditor's comment that we had made some significant improvements based upon actions taken by the Department in response to the previous audit. We specifically appreciate the mention of MEDS' Job Operating Manual as a "notable" improvement. We take great pride in the fact we developed this manual internally in an effort to assist our staff, using clear and understandable language, with the daily process of determining Medicaid eligibility. It is not only a resource for our staff, but helps in our ability to provide excellent customer services to those we serve.

Auditor's Concluding Remarks

Grantees receiving federal awards must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. While controls have improved in this area, we found significant weaknesses that the Department is reluctant to address. These are as follows:

- The Health Care Authority sends a report to the Department monthly of clients who no longer meet the income standards for Basic Health. During our fieldwork, we found that the Department does not act upon the information in these reports.

- The Department believes that there is no requirement to verify income unless it is questionable. However, according to federal requirements listed above, verification of income is mandatory.

- The Department does not follow income verification procedures for all clients.

- The Department should strengthen controls by corroborating income for all clients, not just those who report incomes 200 percent above federal poverty levels. Doing so is equivalent to accepting self-declaration for all those reporting less than 200 percent of the federal poverty level. If the Department does not monitor incomes at all levels, clients may perceive that there is little risk of the Department detecting false income data.

A disregard for control weakness that threatens program integrity may jeopardize future federal funding or may result in increased federal scrutiny for Washington's Medicaid program.

Applicable Laws and Regulations

Title 45, Code of Federal Regulations, Section 92.20(a) states:

> A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

Revised Code of Washington 43.88.160(4) states:

> …the director of financial management, as agent of the governor, shall:
>
> (a) Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each Department that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency and encourage adherence to prescribed managerial policies for accounting and financial controls.

The state of Washington Office of Financial Management's *State Administrative and Accounting Manual* addresses basic principles of internal control in Section 20.20.20.a. as follows:

> Each agency director is responsible for establishing and maintaining an effective system of internal control throughout the agency.

The U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C(1)(d) provides that costs are allowable under federal awards if they meet the following criteria:

> Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.

Title 42, Code of Federal Regulations, Section 435.916(b), states in part:

> …The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.

As it pertains to requesting information for the determination of eligibility, Title 42, Code of Federal Regulation, Section 435.948, states in part:

> (a)…the agency must request information from the sources specified in this paragraph for verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant (unless obviously ineligible on the face of his or her application) and recipient. The agency must request -
>
> (1) State wage information maintained by the SWICA (State Wage Information Collection Agency) during the application period and at least on a quarterly basis.
> (2) Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA and available under Section 6103(1)(7)(A) of the Internal Revenue Code of 1954 for applicants during the application period and for recipients for whom the information has not previously been requested.
> (3) Information about benefit and other eligibility related information available from SSA under titles II and XVI of the Social Security Act for applicants during the application period and for recipients for whom the information has not previously been requested;
> (4) Unearned income information from the Internal Revenue Service available under Section 6103(l)(7)(B) of the Internal Revenue Code of 1954, during the application period and at least yearly;
> (5) Unemployment compensation information maintained by the agency administering State unemployment compensation laws (under the provisions of section 3304 of the Internal Revenue Code and section 303 of the Act) as follows:
> (i) For an applicant, during the application period and at least for each of the three subsequent months;
> (ii) For a recipient that reports a loss of employment, at the time the recipient reports that loss and for at least each of the three subsequent months.
> (iii) For an applicant or a recipient who is found to be receiving unemployment compensation benefits, at least for each month until the benefits are reported to be exhausted.
> (6) Any additional income, resource, or eligibility information relevant to determinations concerning eligibility or correct amount of medical assistance payments available from agencies in the State or other States administering the following programs as provided in the agency's State plan:
> (i) AFDC;
> (ii) Medicaid;
> (iii) State-administered supplementary payment programs under Section 1616(a) of the Act;
> (iv) SWICA;
> (v) Unemployment compensation;

(vi) Food stamps; and Any State program administered under a plan approved under Title I (assistance to the aged), X (aid to the blind), XIV (aid to the permanently and totally disabled), or XVI (aid to the aged, blind, and disabled in Puerto Rico, Guam, and the Virgin Islands) of the Act.

(b) The agency must request information on applicants from the sources listed in paragraph (a)(1) through (a)(5) of this section at the first opportunity provided by these sources following the receipt of the application. If an applicant cannot provide an SSN at application, the agency must request the information at the next available opportunity after receiving the SSN.

(c) The agency must request the information required in paragraph of this section by SSN, using each SSN furnished by the individual or received through verification

(d) Exception: In cases where the individual is institutionalized, the agency needs to obtain and use information from SWICA only during the application period and on a yearly basis, and from unemployment compensation agencies only during the application period….

(e) Exception: Alternate sources.

(1) The Secretary may, upon application from a State agency, permit an agency to request and use income information from a source or sources alternative to those listed in paragraph (a) of this section. The agency must demonstrate to the Secretary that the alternative source(s) is as timely, complete and useful for verifying eligibility and benefit amounts. The Secretary will consult with the Secretary of Agriculture and the Secretary of Labor before determining whether an agency may use an alternate source.

(2) The agency must continue to meet the requirements of this section unless the Secretary has approved the request.

(f) Exception: If …SSA determines the eligibility of an applicant or recipient, the requirements of this section do not apply to that applicant or recipient.

The March 2003 U.S. Office of Management and Budget A-133 Compliance Supplement, Section E(1)(b)(2), page 4-93.778-12 and 4-93.778-13, states the following as it pertains to income verifications for eligibility determination:

There are specific requirements that must be followed to ensure that individuals meet the financial and categorical requirements for Medicaid. These include that the State or its designee shall:…

(2) Use the income and eligibility verification system (IVES) to verify eligibility using wage information available from such sources as the agencies administering State unemployment compensation laws, Social Security Administration, and the Internal Revenue Service to verify income eligibility and the amount of eligible benefits. With approval from HHS, States may use alternative sources for income information. States may also: (1) target the items of information for each data source that are most likely; to be most productive in identifying and preventing ineligibility and incorrect payments, and a State is not required to use such information to verity the eligibility of all recipients; (2) with reasonable justification, may exclude categories of information when follow-up is not cost effective; and (3) can exclude unemployment compensation information from the Internal Revenue Service or earning information from Social Security Administration (SSA) that duplicates information received from another source.

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

The auditee shall:…

(b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-13

The Department of Social and Health Services, Aging and Disability Services Administration and Medical Assistance Administration, has not set up an effective system of communication that would ensure that Medicaid payments are not being made to nursing homes that are not in compliance with federally mandated health and safety standards.

Background

Under the Medicaid program (CFDA 93.778), states can receive federal financial assistance for patients receiving services in nursing homes. To qualify for federal participation, the nursing home must meet certain health and safety standards. The Department's Aging and Disability Services has primary responsibility for conducting health and safety inspections at nursing facilities. Should Aging and Disability Services find that a nursing facility is not meeting federal standards, upon notification from Aging and Disability Services, the U.S. Department of Health and Human Services will send both the facility and Aging and Disability Services a denial of payment notice. This notice prohibits the payment of federal funds for any new Medicaid admissions to the facility until the condition is corrected. The Department's Medical Assistance Administration has primary responsibility for reviewing and paying claims of medical providers. Once notified of a nursing facility's denial-of-payment status, it is also Medical Assistance's responsibility to ensure that payments for services to ineligible clients are not reimbursed.

Description of Condition

During our 2002 audit, we found that neither Aging and Disability Services nor Medical Assistance had a complete record of the nursing homes that were placed in denial-of-payment status. We compared both administration's records with the list maintained by the federal government and found Aging and Disability Services to have a 14 percent discrepancy rate and Medical Assistance to have a 33 percent discrepancy rate. During that audit, the Department concurred with our results and instituted a corrective action plan through which Medical Assistance would track the denial-of-payment notices directly from the federal government.

To determine whether this internal control improved the accuracy of the Department's records in our current audit, we compared the federal government's denial-of-payment list with the records of Medical Assistance for 36 nursing homes. We found the following:

- Medical Assistance records showed 19 of 36 nursing homes, or 53 percent, that were not matched to the federal government's list.

- Medical Assistance performs no monitoring to ensure that unallowable payments were not paid to nursing homes in facility's denial-of-payment status.

Cause of Condition

The increased discrepancy rate occurred because:

- Medical Assistance it not accurately tracking the denial-of-payment notices issued by the federal government.

- Aging and Disability Services and Medical Assistance do not communicate regarding nursing homes that are not in compliance with health and safety standards. Such communications would alert Medical Assistance of the possible existence of a facility's denial-of-payment notice.

Effect of Condition

Due to inadequate internal controls, there is a risk that the Department paid claims for ineligible patients using federal Medicaid funds.

Recommendations

Medical Assistance should improve its system for tracking the denial-of-payment notices issued by the federal government and monitor the allowability of payments to nursing homes that are in denial-of-payment status. As a preventative measure, we also recommend Aging and Disability Services inform Medical Assistance of the nursing homes that it reports to the federal government as not meeting health and safety standards and therefore likely to be placed in denial-of-payment status.

Department's Response

The Department of Social and Health Services, Aging and Disability Services Administration and Medical Assistance Administration, partially concurs with this finding.

The Department concurs that MAA needs to review current practice to add or strengthen current internal controls that would ensure the following:

- *Method of communication between MAA and CMS is timely and accurate;*
- *Monitor payments to nursing homes that are in DOP status are accurate.*

The Department does not concur that ADSA has a role in the communication between MAA and CMS with regard to the DOPs. CMS has agreed to send a copy of all DOPs to both ADSA and MAA upon issuance, therefore preventing the need for either program to have to track these documents at the agency level.

Auditor's Concluding Remarks

The corrective action plan instituted by the Department in 2002 to correct the deficiencies found in our 2002 audit is not working as management had intended. Rather than improving the condition, we saw a deterioration of controls and an accompanying increase in the risk that nursing homes may be paid with federal funds when they are not in substantial compliance with health and safety standards.

Our Office takes the position that it would be most expedient for the Administration that performs the nursing home survey (ADSA) to communicate with the Administration that pays the nursing homes (MAA) for their services when they have complied with health and safety requirements. Given the current controls, we reaffirm our position that there is a risk that nursing homes are being improperly reimbursed for services when they are in denial of payment status. Further, the apparent lack of communication between the two Administrations can threaten program integrity.

Applicable Laws and Regulations

Title 42, Code of Federal Regulations, Section 442.112 (a) states:

> The Medicaid agency may not execute a provider agreement or make Medicaid payments to a facility unless the Secretary or the State survey agency has certified the facility.

Title 42, Code of Federal Regulations, Section 442.119 states:

> The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, the state finds the facility corrected the deficiency or is making a good faith effort to achieve compliance.

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…

(b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-14

The Department of Social and Health Services, Medical Assistance Administration, is not complying with subrecipient monitoring requirements for the Medicaid Program.

Background

State agencies often distribute federal funds to other organizations that provide services needed to accomplish federal program objectives. These organizations are known as subrecipients, while the state agencies are called pass-through agencies. To help ensure that funds are spent appropriately, the federal government requires pass-through agencies to monitor the activities of subrecipients to provide reasonable assurance that they are complying with federal requirements. Monitoring may take various forms such as reviewing reports submitted by subrecipients and performing on-site reviews of subrecipient financial and program records and operations. Monitoring also includes providing subrecipients with program information, such as the award name and Catalog of Federal Domestic Assistance number, the name of the awarding federal agency, and federal requirements for the program. For subrecipients spending $300,000 or more in federal awards during a fiscal year, pass-through agencies must ensure the performance of appropriate audits, respond to subrecipient audit findings, and ensure appropriate and timely corrective action.

Description of Condition

During our audit of the Medicaid program (CFDA 93.778), we evaluated the Department's system of monitoring local health jurisdictions that participate in the Medicaid Administrative Match program. The activities performed by the local health jurisdictions include providing information about the Medicaid program to clients, helping potential Medicaid-eligible clients through the application process, and enhancing the ability of Medicaid-eligible clients to access Medicaid services. Those local health jurisdictions that perform these activities are reimbursed for 50 percent of their costs with federal Medicaid funds.

Thirty-two county health departments and 13 Indian nations participate in this program. Our review found that approximately 44 percent of the local health jurisdictions have never been monitored by the Department. These jurisdictions received $1,612,393 in federal Medicaid funds in state fiscal year 2002. This accounts for approximately 15 percent of the program's funding for that year. Further, these jurisdictions have been receiving funds from the Medicaid Administrative Match program since at least December of 1997.

Cause of Condition

The Department was aware the local health jurisdictions were subrecipients, but stated it had only one employee to monitor both the local health jurisdictions and school districts that participate in the program. Between the two, 245 entities must be monitored.

Effect of Condition

Without proper monitoring, the Department cannot ensure that subrecipients are complying with federal requirements and that subrecipient claims for reimbursement are calculated correctly and adequately supported.

Recommendations

We recommend the Department devote the resources necessary to ensure compliance with subrecipient monitoring requirements.

Department's Response

The Department of Social and Health Services, Medical Assistance Administration, partially concurs with this finding.

The Department agrees that only 44% of the entities contracted with had on-site visits. However, monitoring can and does take various forms, as stated above. Some of the methods employed by DSHS included:

- *Reviewing reports submitted by subrecipients. This includes the review of the monthly billings received by DSHS that have supporting documentation attached and through the program/progress reports that provide DSHS with the status of the program along with current measurements.*
- *Providing subrecipients with program information in the contract. Such items provided include the award name and Catalog of Federal Domestic Assistance number, the name of the awarding federal agency, and federal requirements for the program.*
- *Providing assistance through phone, written correspondence, and email on contract requirements, new program requirements or discussing with them issues with regard to current day to day activities.*
- *Review of the entities annual audit report. If findings are noted, following up with the entity with regard to their corrective action plan taken.*

It is through these methods that MAA has been monitoring all of their subrecipients.

Auditor's Concluding Remarks

In its response, the Department identified its methods of monitoring. We have no objection to these methods. Our primary concern is the lack of procedures that ensure subrecipient claims for reimbursement are calculated correctly and adequately supported. The Department receives monthly billings from the subrecipients. However, these billings are simply representations made by the subrecipients. They are not accompanied by supporting documentation. Additionally, the Department could not provide us with monitoring reports for those sites it stated it had reviewed subrecipient billings.

The Department does not ensure that each local health jurisdiction expending $300,000 or more in federal awards annually receives a Circular A-133 audit as required. If an audit was performed, the Department will review the report. However, if an audit was not performed, the Department makes no effort to ensure compliance with Circular A-133.

Applicable Laws and Regulations

U.S. Office of Management and Budgets Circular A-133, *Audits of States, Local Governments, and Non-profit Organizations,* Section 400(d) states, in part:

A pass-through entity shall perform the following...

1. Identify Federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year….and name of Federal agency…

2. Advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of contract or grant agreements as well as any supplemental requirements imposed by the pass-through entity.

3. Monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

4. Ensure that subrecipients expending $300,000 or more in; Federal awards during the subrecipient's fiscal year have met the audit requirements of this part for that fiscal year.

5. Issue a management decision on audit findings within sic months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.

6. Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.

03-15

The Department of Social and Health Services, Aging and Disability Services Administration, cannot determine whether nursing home payment rates properly excluded unallowable expenditures related to supplemental Medicaid payments.

Background

Supplemental Medicaid funds (CFDA 93.778) are provided to eligible public hospital districts to preserve access to health care services in rural areas. These supplemental funds are referred to as Proshare. In state fiscal year 2000, the state made Proshare payments totaling approximately $147 million to public hospital district nursing facilities that met the eligibility criteria. This resulted in the state receiving $76.2 million in Federal matching funds. Of the $147 million distributed, the allocation was as follows:

- $127 million was transferred back to the state.
- $10.2 million was shared with three non-profit organizations.
- $9.8 million was retained by 14 public hospital district nursing facilities.

Nursing facilities that provide care for Medicaid patients are reimbursed by the state using a standard daily rate for each patient. The daily rate is based on expenditures of the nursing facility. The $9.8 million in supplemental funds received by the nursing facilities was in addition to the Medicaid payments they received for direct patient care. Because these supplemental Proshare payments are not related to direct patient care, the State Medicaid Plan requires that expenditures from Proshare funds be excluded from the calculation of the daily rate. Except for inflation, nursing home payment rates have not been adjusted since 1999. The daily rate established in 1999 would have taken into account all expenditures of the nursing homes, including those attributable to the supplemental Proshare payments.

Description of Condition

The Department had no documentation that provided reasonable assurance that expenditures attributable to Proshare payments were not used in the calculations that set the nursing homes rates from July 1, 2001 to present. In two of the five cost reports that we reviewed, Proshare revenues were reported by the nursing homes, but expenditures attributable to Proshare were not identified.

Four out of the five analysts that we interviewed reported that they were unaware of Proshare payments and thus did not consider any expenditures related to it in their analyses. However, one analyst did consider these payments and attempted to obtain Proshare expenditure information from a nursing home, but was overridden by management when the nursing home complained to the Department. Consequently, the nursing home made no offset for the expenditures made from Proshare funds.

As an alternative internal control, the Department stated it had other measures built into its rate setting procedures that would have compensated for its decision not to exclude expenditures attributable to Proshare. However, for the nursing homes we reviewed, the Department could not provide evidence that would conclusively support this contention.

Cause of Condition

- In general, Department analysts were unaware of the significance of Medicaid supplemental payments in nursing home rate setting.

- The Department management did not enforce the terms of the supplemental payments as they pertain to nursing home rate setting when it was made aware of the possible existence of such expenditures.

- The Department did not comply with its own audit procedures in requiring adequate documentation to determine whether Proshare funds were used to set the nursing home rate for the 14 hospitals receiving Proshare funds.

Effect of Condition

There is a risk that the current nursing home rates are inflated for those facilities that received Proshare funds in 1999. These inflated rates would have been in effect since July 1, 2001 and will continue until the next nursing home rates are set.

Due to a lack of documentation, we could not recalculate an accurate daily nursing home payment rate for the facilities tested and therefore cannot determine potential questioned costs.

Recommendations

We recommend that the Department:

- Follow its own audit procedures and ensure that supporting schedules detailing expenditures attributable to Proshare and other unallowable revenues are present in cost reports and that these expenditures are appropriately offset.

- Consult with the U.S. Department of Health and Human Services to determine if nursing home rates should be recalculated to identify possible unallowable costs charged to Medicaid.

Department's Response

The Department of Social and Health Services, Aging and Disability Services Administration, partially concurs with this finding.

The Department does not concur that there is any reasonable possibility that the 1999 cost year was distorted by improper inclusion of expenses paid for by Proshare money. Total expenditures reported by the PHD nursing facilities do not support the idea that the facilities significantly increased their spending due to receipt of the Proshare money. From 1996 to 1997, the PHD facilities showed an average increase in costs of 7%. From 1997 to 1998, the average change was zero. From 1998 to 1999, the average increase was again 7%. These figures are in line with both general inflation and the spending of non-PHD nursing facilities, which did not participate in Proshare. For example, between 1998 and 1999 – when the PHD facilities reported a 7% increase – all nursing facilities participating in Washington's Medicaid program reported an increase of 8%.

Washington's rate-setting process contains caps on various costs. Moreover, not all costs of a nursing facility are allowed into the calculation of Medicaid rates. When caps and disallowances for the 14 PHD facilities are taken into account, the potential amount of Proshare-funded expenditures that could conceivably have been used in the rate-setting process is decreased from $9.8 million to $3.895 million.

Further, it should be noted that the Proshare money was distributed late in 1999 - on September 30 and November 15. This makes it even less likely that the 1999 cost reports were significantly affected by expenditures covered by Proshare funds – if indeed there were any such expenditures at all.

For the reasons stated above, the department does not support the auditors view that there is a risk that current nursing home rates are in any significant way inflated by inclusion of Proshare-funded expenses in the rate-setting process for PHD nursing facilities. However, the department will continue to investigate the situation and, as the agency in charge of administering Washington's Medicaid program, will take action where appropriate.

The Department does concur that not all analysts in the Nursing Home Rates Section were aware of the existence of the Proshare payments to the PHD nursing facilities. The section manager will inform the analysts of the Proshare program, and of the restriction on the expenditure of Proshare payments, so that this matter will be monitored in the future. Participating facilities will be directed to report their expenditure of Proshare funds, so that it can be confirmed that such expenditures are not included in the Medicaid rate-setting process. The Nursing Home Rates Section will coordinate its efforts with the department's Medical Assistance Administration to ensure that Proshare funds are spent properly, and that this can be confirmed.

Auditor's Concluding Remarks

In its response, the Department stated there is no reasonable possibility that the 1999 cost year was distorted due to the improper inclusion of expenses attributable to Proshare revenues. We believe this statement is speculative and cannot be ascertained as fact. The Department could offer no evidence that rate caps, average facility spending, and the time of year that Proshare funds were distributed compensated for its failure to determine whether or not nursing homes excluded expenditures attributable to Proshare for rate setting purposes. That facilities would not use expenditures covered by supplemental payments for rate setting was a condition for receipt of the funds.

Rate adjustments have a significant effect on nursing homes operations. In fact, nursing homes will apply for and submit to the rigors of a rate adjustment for an increase of one penny per patient day. This is because even such a small increase can result in substantial reimbursements to the facility over the course of a year. Further, the Department informed us that providing resources for this process is not viewed as a misuse of taxpayer dollars. Therefore, by not accounting for the expenditures related to Proshare revenues, nursing homes that received these funds may be operating under an inflated rate.

The Department's lack of controls for ensuring that Proshare funds are properly disclosed could result in increased federal oversight of the Medicaid program.

Applicable Laws and Regulations

The Medicaid State Plan, Attachment 4.19-D, Part 1, states:

> The supplemental payments made to public hospital districts are subject to ... a contractual commitment by the districts to not allow expenditures covered by the supplemental payments to be included in costs used to set Medicaid nursing facility payment rates.

The terms of the Interlocal Agreement executed by the public hospital districts and the Department states, in part, in Exhibit A, paragraph 1.b:

> The Public Hospital District (Contractor) will: …Not allow expenditures covered by supplemental payments to be used for Medicaid nursing home rate setting.

03-16

The Department of Social and Health Services, Medical Assistance Administration, has not established sufficient internal controls to ensure compliance with Medicaid provisions regarding licensing and other eligibility criteria for its health care providers.

Background

The Department of Social and Health Services administers the state of Washington Medicaid program (CFDA 93.778), which receives nearly $3 billion in federal funds annually. These funds pay medical providers for health care services to certain low-income clients.

Medical care under Medicaid is offered through certified and/or licensed health care providers. To become eligible to receive reimbursement for services, providers must apply for a provider number as well as meet state licensure requirements. This latter requirement assures the Department of the providers' qualifications to perform the services for which they wish to be paid. In the case of group practices, each individual practitioner must meet the licensure requirements. Evidence of current licensure for all practitioners of the group must be submitted with the application. After an application is approved and processed, the provider is deemed eligible and a provider number is issued and activated within the Medical Management Information System (MMIS). This number, when accompanied by a claim, will allow MMIS to generate an approval so that payment can be made to the provider.

Description of Condition

During our 2001 audit, we found significant weaknesses in the internal controls designed to ensure that providers meet licensing requirements.

Our 2002 audit revealed significant improvements to the internal control structure, but these improvements were only in the preliminary stages of implementation. Some of the enhancements included changes to the Core Provider Agreement; the development of a new provider expiration report; and a massive re-enrollment of all the providers. In terms of re-enrolling providers, those who did not submit an application and meet all necessary licensing criteria by the Department's deadline were to be terminated from eligibility and their provider numbers would be inactivated.

During our current audit, we reviewed the progress that the Department has made. We reviewed the licensure status of 169 dental practitioners, 106 chiropractors and nine medical practitioners. We found the following exceptions for dental and chiropractic providers:

Condition	Number
Expired license, but still listed as active in Medical Assistance Administration records.	16
Active restrictions on license, but no restrictions noted in Medical Assistance Administration records.	1
Deceased provider, but still listed as active in Medical Assistance Administration records.	3
Suspended license in Department of Health records, but still active in Medical Assistance Administration records.	1
License information erroneously listed in Medical Assistance Administration records.	2
No licensing information in Medical Assistance Administration records, but found in Department of Health records.	35
Previous disciplinary action or restriction on license, no indication that Medical Assistance Administration was aware of the action.	4

In addition, we found:

- Licensees were linked to clinics and practice groups that they have not been affiliated with for up to 11 years.

- The providers that we found to be deceased, but still active in MAA records, had been dead for up to seven years.

- Providers listed as active in Medical Assistance Administration records, but whose licenses had expired nine years before.

Finally, we found inadequate supervisory overview of the initial approval process for providers. Management is relying on staff to accurately follow complex procedures for the many types of providers that they enroll.

Cause of Condition

- The provider enrollment termination deadline initially set for January 2003, which would have terminated the provider numbers for all providers who have not re-enrolled, has not been enforced.

- No controls are in place to detect claims from providers who have a condition or restriction placed on their licenses.

- The Department is generating letters on a monthly basis to inform providers of the impending expiration of their licenses and to require them to update their licensure status. However, as of the date of our audit, the Department had never mailed these letters.

- The Department does not have controls in place to detect claims from providers whose licenses have been suspended or revoked by the Department of Health. On a monthly basis the Department of Health sends the Medical Assistance Administration all pertinent licensing information for all practitioners in the state. This data set contains information that would alert the Department of important licensing changes such as suspensions, revocations, practice restrictions and expirations. The Department is not updating its Medical Management Information System with this information.

- The Department stated it lacks sufficient resources to review the work of its staff.

Effect of Condition

- By not enforcing the provider enrollment termination deadline, deceased providers, providers whose affiliations have ended with past practice groups, and providers with inactive licenses cannot be easily removed from the Medical Management Information System.

- Providers whose licenses have expired or that have been suspended or revoked; providers who are deceased; and individuals who are not actively licensed are active in the Department's records. This condition leaves the Department susceptible to fraud.

- While the Department was able to provide sufficient evidence to give us reasonable assurance that no claims were paid for services performed by the unlicensed providers that reviewed, almost 6 percent of them had provider numbers that were individually payable and active in its Medical Management Information System. This leaves the Department susceptible to fraud as it is possible for these provider numbers to be used to receive payment.

- Twelve percent of the providers that we reviewed have no licensing information listed in Medical Assistance Administration records. Controls that require licensing data such as expiration dates would not function properly.

- It is possible for providers to be paid for procedures that they are no longer licensed to perform.

Recommendations

We recommend that the Department:

- Establish and enforce a termination deadline for providers who have not re-enrolled. This would automatically eliminate those providers who are deceased and whose licenses have expired and whose affiliations are no longer valid.

- Update its Medical Management Information System with the monthly licensing data sent by the Department of Health.

- Establish controls that would ensure that claims submitted by providers who have practice restrictions associated with their licenses are not reimbursed for services they are no longer licensed to perform.

- Send the letters of expiration generated by its Medical Management Information System to providers on a monthly basis when no active license is listed on the Department of Health website.

- Provide the resources needed to enable the Medical Assistance Administration to ensure the initial approval process is conducted as management intends.

Department's Response

The Department of Social and Health Services, Medical Assistance Administration, concurs with this finding. DSHS has or will implement the following to address the weaknesses that were noted in this finding:

- *Established a deadline of December 31, 2003 for the provider re-enrollment project. This deadline will enable MAA to terminate the providers that have not re-enrolled because they have deceased, expired licenses, moved, or sold their practices. This will clean up the provider files.*

- *Establishing a process in the provider enrollment unit that if a provider has limitations on their professional license and the license is still active, we are going to send that information to Quality Management Section to determine how or what type of limitation will be placed on their provider file. DSHS would like to note that the Provider Enrollment does place restrictions on a provider file now upon request, but it will expand the criteria to include license limitations.*

- *MAA currently receives the list of excluded providers from the OIG to terminate the provider numbers monthly. DSHS will be matching the Department of Health (DOH) license database with the provider file database monthly within the next few months. We are also doing a match with another project we are working on in conjunction with the Health Care Authority and Labor and Industries to match license numbers with our license numbers by provider number.*

- *Established a core provider agreement database that holds information about each core provider agreement that is sent in. This will track that status of the Core provider agreement. Also, there will be a report generated once a week that indicates problems with the provider file if claims are not paying correctly.*

MAA will develop a plan to improve monitoring and oversight to ensure procedures for the initial approval process are conducted as management intends.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issues identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

Title 45, Code of Federal Regulations, Section 92.20(a), states:

> A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

The March 2003 OMB Circular A-133 Compliance Supplement, page 4-93.778-18, states:

> In order to receive Medicaid payments, providers of medical services furnishing services must be licensed in accordance with Federal, State, and local laws and regulations to participate in the Medicaid program (42 CFR sections 431.107 and 447.10; and section 1902(a)(9) of the Social Security Act) and the providers must make certain disclosures to the State (42 CFR subpart B)

U.S. Office of Management and Budget Circular A-133*, Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states:

> The auditee shall:…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs….

03-17

The Department of Social and Health Services, Medical Assistance Administration has not established sufficient internal controls to ensure that capitation rates for its managed care providers are based on accurate fee-for-service encounter data.

Background

The Department of Social and Health Services administers the state of Washington Medicaid program (CFDA 93.778), which receives nearly $3 billion in federal funds annually. These funds, matched almost entirely by state funding, pay medical providers for health care services for certain low-income people. A state may obtain a waiver of statutory requirements in order to develop a system that more effectively addresses its residents' health care needs. A waiver may involve the use of a program of managed care for some clients or allow the use of program funds to serve specific clients that would be otherwise ineligible. Such programs must meet statutory and regulatory requirements for access to care and quality of services and must be a cost-effective means of providing health care services to the state's Medicaid population. The Healthy Options Program is Washington's managed care waiver and is authorized under sections 1915(b)(1) and (4) of the Social Security Act.

A capitation rate is a uniform per-patient payment that is paid to a managed care provider who treats a Healthy Options client. The provider will receive a consistent monthly payment rate for each client regardless of the number of times a client is seen and regardless of the service that is rendered as long as it is a covered service. Provider billing information and fee-for-service data (or the client diagnostic data and cost-per-visit for clients not enrolled in managed care) are used to determine the managed care capitation rate.

The rate for each managed care plan is determined using all available hospital data, with the exception of pharmaceutical data. It includes demographic, diagnostic, and geographic data, as well as hospital fees. The data is analyzed by an actuary who predicts the cost of care for the next year. From this information, a rate for each Healthy Options managed care plan is determined. In general, those plans that have sicker people will receive higher rates and those plans with healthier people will be given lower rates.

Description of Condition

We reviewed the Department's controls to determine if procedures have been established to ensure that only accurate data is being used to determine the capitated rates for its Healthy Options managed care program. We found the following:

- An outside actuary assumes responsibility for accuracy of the results of the rate computation. However, the fee-for-service data downloaded from the Medical Assistance Administration systems is generally not reviewed by the Department unless the data is rejected by computer system edits. The reliability of this data is crucial as it determines what will be paid to managed care providers.

- Although fraud detection, enforcement, and prevention procedures are being developed and refined, only certain types of provider billings (for example, dentists and pharmacists) are currently being analyzed and pursued.

- Data comparing the fee-for-service costs to the Healthy Options Managed Care costs are not easily or readily obtainable within the Medical Assistance Administration system for analysis. The Department was unable to provide us with this data during our audit.

Cause of Condition

Only certain segments of provider fee-for-service billings are currently being reviewed. Unexamined data that contains undetected errors may be used to determine managed care capitation rates.

Medical Assistance is unable to readily review or compare the cost of the fee-for-service part of Healthy Options to Managed Care Healthy Options.

Effect of Condition

If fee-for-service encounter data is incorrect, it calls into question the accuracy of the managed care rate, resulting in increased premium rates being paid to managed care plans over time, at significant cost to state and federal government. In state fiscal year 2002, the state spent in excess of $481 million for services to managed care enrollees.

The inability to effectively analyze Healthy Options Managed Care as compared to fee-for-service affects the potential identification of cost containment measures and leads to possible inequities between managed care and fee-for-service options for Healthy Options eligible clients.

The Department's lack of monitoring may lead to an increased risk for the submission of incorrect data by providers, causing capitation rates to be greater than they should be.

Recommendations

We recommend that the Department:

- Continue to develop its fraud detection, enforcement, and prevention procedures for fee-for-service provider claims expanding to all provider areas.
- Develop formal procedures for referral to the Medicaid Fraud Control Unit or other enforcement action.
- Review the use of data used in setting capitation rates to ensure that rates are not affected by erroneous fee-for-service data.

Department's Response

The Department of Social and Health Services, Medical Assistance Administration, does not concur with this finding.

The auditor misunderstood the rate setting process and that misunderstanding placed too much importance on Fee For Service (FFS) and encounter data in current rate setting. What was presented to the auditor showed the rate setting process in managed care from its inception to present (including 2002).The rate setting process has always been reviewed and approved by CMS. In 2002 that process was focused on staying under a FFS equivalent, the Upper Payment Limit (UPL), which DSHS accomplished. With the Balanced Budget Act final rules, the focus changed to rates developed from direct costs. We are making that change as part of a CMS approved corrective action. Our rates have been reviewed and approved by CMS through 2005.

Since the final finding and recommendations are focused on Fraud and Abuse, it is important to understand that Fraud and Abuse policies and procedures are in place and compliant with CMS guidelines for managed care and that current and future FFS Fraud and Abuse is irrelevant to current and future managed care rate setting. The only FFS data that has ever entered into rate setting is from 1993.

Auditor's Concluding Remarks

We have a complete understanding of the rate setting process. The capitation rate (a per patient rate the managed care provider will receive) is predicated on the type of treatments given and the types of patients seen. "Up-coding" occurs when a provider bills for a higher level of services than what was actually provided. If up-coding occurs, it will falsely give the impression that the provider is treating sicker people than they really are. The federal government has reported that up-coding is not uncommon and is done so that the capitation rate can be negotiated higher and ostensibly be justified in future years.

The documentation that the Department is providing to the actuary is not reviewed or audited for accuracy. If up-coding occurs, the Department has no controls in place that could detect the erroneous information. As long as this unmonitored fee for service encounter data is given weight as a component of rate setting, there is risk that rates will rise to a level higher than they should be.

The effects of up-coding, when perpetrated by managed care providers, may not be realized until some time in the future, if ever. Additionally, up-coding by managed care providers may not be subject to prosecution for fraud under the traditional false claims theory. This is because the managed care plan is not receiving money or any other type of constructive gain at the time treatment is given. Additionally, if the Department does not monitor the data, managed care plans may perceive the risk of detection as being relatively low.

With respect to federal oversight in this process, the Center for Medicare and Medicaid Services (CMS) approves of the process by which the rates are set. The rate is determined primarily by the work of the actuary and is based on the information given by the Department. This actuarially computed figure becomes the rate once approved by the legislature.

Applicable Laws and Guidelines

The March 2003 OMB Circular A-133 Compliance Supplement, page 4-93.778-16, states:

- The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services.

- The State Medicaid agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services.

- The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

Title 42, Code of Federal Regulations, Section 456.3 states the following as it pertains to surveillance and utilization control:

> The Medicaid agency must implement a statewide surveillance and utilization control program that -
> (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
> (b) Assesses the quality of those services;
> (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part…

03-18

The Department of Social and Health Services did not comply with federal time and effort reporting requirements for its Rehabilitation Services grant.

Background

The Department of Social and Health Services administers the Rehabilitation Services-Basic program (CFDA 84.126) in the state. The objective of this program is to provide vocational rehabilitation services for individuals with disabilities so that such they may prepare for and engage in gainful employment. The Department reported total federal program expenditures of $48,921,833 for fiscal year 2003.

Description of Condition

For payroll costs charged directly to federal awards, federal regulations require employees to document the time and effort spent on each federal activity monthly. These monthly records must reflect the actual distribution of the employee's activities. However, if an employee works on only one federal activity, semi-annual certifications signed by the employee or a supervisor meet federal requirements.

During our review of payroll charges, we noted that the Department charged $17,542,438 in salaries and benefits to the grant for employees working directly in the program statewide in fiscal year 2003. This is about 35 percent of the total grant outlays. Over 300 employees worked full time on vocational rehabilitation duties, however, we found that the Department did not require these employees to certify their time and effort spent working on the grant program as required by federal regulations.

Cause of Condition

The Department was not aware of the federal requirements over time and effort reporting for employees who work 100 percent on a grant program.

Effect of Condition

Without time and effort certifications, the federal grantor cannot be assured that wages charged to its program are accurate and valid. However, in considering the nature of the job duties and responsibilities of each field office, we feel the risk is low that the 300 employees were performing duties other than vocational rehabilitation and therefore will not question the costs.

Recommendation

We recommend the Department require employees who work 100 percent on a single federal program to certify, in writing, their time spent working on the program on a semi-annual basis. It is also acceptable for an employee's supervisor to sign the semi-annual certification on behalf of the employee, provided the supervisor has first hand knowledge of the work performed by the employee.

Department Response

The Department concurs with the finding and will implement semi-annual certifications. We disagree with the statement that "…the federal grantor cannot be assured that wages charged to its program are accurate and valid". These employees are not only assigned to work on a single federal activity, there is only one federal activity to charge them to. The risk is low, if any, that the 300 employees were performing duties other than vocational rehabilitation.

Auditor's Concluding Remarks

We appreciate the Department's commitment to resolve the issue identified in the finding. We also appreciate the cooperation extended to us throughout the audit by Department staff.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment B, Section 11(h), states in part:

(1) Charges to Federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payrolls documented in accordance with generally accepted practice of the governmental unit and approved by a responsible official(s) of the governmental unit.

(2) No further documentation is required for the salaries and wages of employees who work in a single indirect cost activity.

(3) Where employees are expected to work solely on a single Federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having first hand knowledge of the work performed by the employee.

03-19

The Department of Social and Health Services, Economic Services Administration, should improve compliance with eligibility requirements for the Temporary Assistance to Needy Families Program.

Background

The Department of Social and Health Services, Economic Services Administration, is responsible for administering the federal Temporary Assistance to Needy Families program (CFDA 93.558). Federal regulations require each state to maintain a certain amount of state-funded expenditures each year or face financial penalties. For assistance payments to clients, the Program expended $107,796,402 in federal funds and $172,975,130 in state funds during state fiscal year 2003.

The program is designed to provide time-limited assistance to needy families with children and to promote job preparation and work opportunities for the parents. As long as minimum requirements are met, states have flexibility in designing programs and determining eligibility requirements and may use grant funds to provide cash or non-cash assistance. To be eligible under federal requirements, a family generally includes a child under 18 living with the parents and must qualify as needy under a state's criteria. The state also has specified that, with certain exceptions, applicants must provide Social Security numbers in order to receive Program benefits.

During the fiscal year 2002 audit, we identified weaknesses related to compliance with eligibility requirements and reported them in the Statewide Accountability Report and in the State of Washington Single Audit Report.

Description of Condition

During our current audit of the Program, we selected clients who received benefits from July 1, 2002 through May 31, 2003. We again found instances of noncompliance with eligibility requirements in the following areas:

a. From the population of Program recipients, we judgmentally selected 19 active recipients who were 17 years or older, had an average monthly income of $2,500 or more, and received over six months of Program assistance. We compared income records of these families on record at the Employment Security Department, along with the number of family members, with the amounts of Program assistance provided. According to state regulations (Washington Administrative Code 388-478-0035), a family of 10 or more cannot have income in excess of $2,566 a month and still receive Program benefits. We found 10 instances (53 percent of the selected cases) in which the Department paid families more than they were eligible to receive, considering their income and number of family members. Total overpayments in these 10 cases amounted to $37,124.

b. We reviewed the validity of Social Security numbers for 28 Program recipients. We selected only those who were active recipients, had a Social Security number of a person reported to the Social Security Administration as deceased before July 1, 2002, and had received over six months of assistance. Through the use of the Department's access to the Social Security Administration's State on Line Query system, we found 10 instances in which the Social Security numbers could not be verified as accurate. Total Program payments to these ineligible recipients amounted to $9,787. Also, we found 13 instances in which invalid numbers appeared to have been entered because of Departmental error, rather than because of inaccurate information provided by clients. Program payments in these instances, which we determined were probably valid in spite of the incorrect numbers, totaled of $14,402.

c. We found instances in which Program recipients did not have a Social Security number at all. From these recipients, we selected only those who were active recipients, were 18 years or older, and had received over six months of Program assistance. Of the 26 we reviewed, we found 24 U.S. citizens or qualified aliens who had applied for a Social Security number and therefore are eligible for Program assistance. We found two cases in which payments were made to undocumented aliens who provided accurate information but who did not meet the five-year residency requirements in state regulations. Program payments in these two cases totaled $2,118.

Cause of Condition

a. The Department stated this condition was caused by clients providing inaccurate income data, or not promptly advising Department workers of a change in income. In addition, the lag between the availability of Employment Security Department data and comparing it against Program income eligibility contributes to staff not always identifying overpayment cases.

b. The Department stated this condition was caused by staff inattention to detail when entering data primarily due to time constraints in processing cases. Contributing factors also include staff turnover and lack of continued training.

c. These two cases were likely caused by a discrepancy in the Department's manual. The manual indicates these clients were exempt from the five-year requirement; however, the official version of the Washington Administrative Code does not exempt them. In addition, the Department stated the complexity of non-citizen eligibility for Department benefits contributes to the two errors noted.

Effect of Condition

Clients who may not be eligible are receiving both state and federal benefits. In addition, failure to use all resources available for verifying eligibility could leave the Department susceptible to fraud and could lead to a reduction in federal grant funds. The Department estimates that, for the $49,029 identified above, $20,840 was charged to the federal program and $28,189 was charged to state funds. Accordingly, we are questioning these amounts.

Recommendations

We recommend the Department:

- Periodically compare information provided by recipients with applicable records maintained with other state agencies and investigate any discrepancies.

- Require employees to follow state regulations regarding Social Security numbers and investigate and resolve invalid numbers.

- Ensure its manual accurately reflects the applicable current Washington Administrative Codes.

Department's Response

a. The State Auditor's Office judgmentally selected 19 active recipients and tested income records of these families at the Employment Security Department. Their testing resulted in 10 overpayments amounting to $37,124. DSHS concurs that the selected cases were overpaid TANF cash benefits. However, State of Washington statute RCW 74.08.060 stipulates that applicants be assessed for financial assistance within 45 days. Given this state's mandated guideline to provide timely assistance, the delay in up-to-date information through Employment Security Department directly affects our ability to make 100% accurate eligibility decisions at the time of application with the information available. In order to comply with State guidelines, DSHS workers are faced with providing time sensitive, necessary assistance to clients, while diligently following State mandated guidelines. The 19 judgmentally selected cases are not representative of the caseload as they were not randomly selected.

b. The State Auditor's Office reviewed the validity of Social Security numbers for 28 program recipients. There were 10 instances where the Social Security numbers could not be verified as accurate. This resulted in ineligible recipients receiving $9,787. Economic Services Administration concurs with this finding. The department currently has the means to validate recipients Social Security numbers and is addressing this issue through continued staff training. Future system enhancements will reduce these types of errors. The 28 selected cases are not representative of the caseload.

c. The auditor's tested 26 program recipients that did not have a Social Security number at all. The auditor's noted 2 cases totaling $2,118 where the clients provided accurate information, but did not meet state regulations for eligibility. Economic Services Administration concurs with the auditor's finding where

undocumented aliens provided accurate information, but due to an error in the DSHS manual, these clients were authorized Program assistance. The DSHS on-line manual has been corrected to align with WAC, as it should have before these two instances.

Auditor's Concluding Remarks

a. We had not intended for our test selection results to be representative of the TANF recipient population. We used Computer Assisted Audit Techniques to select the clients that we believed were most likely to be ineligible for the benefits they received.

b. We had not intended for our test selection results to be representative of the TANF recipient population.

c. We appreciate the Division's prompt response to this issue.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states in part:

> The auditee shall…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs…

Circular A-133, Subpart A, Section 105, states, in part, a questioned cost means a cost that is questioned by the auditor because of a finding:

> (1) Which resulted from a violation or possible violation of a provision of law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the use of Federal funds, including funds used to match Federal funds:

Circular A-133, Subpart E, Section 510, includes the following as audit findings the auditor shall report in a schedule of findings and questioned costs:

> (a)(3) Known questioned costs which are greater than $10,000 for a type of compliance requirement for a major program.

Washington Administrative Code 388-478-0035 describes the maximum earned income limits for Program beneficiaries relative to the number of family members.

Washington Administrative Code 388-476-0005 states in part:

> (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security Number (SSN) or numbers if more than one has been issued.
>
> (2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:
>
> (a) Apply for the SSN;
> (b) Provide proof that the SSN has been applied for; and
> (c) Provide the SSN when it is received.
>
> (3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

Washington Administrative Code 388-424-0010 (2) and (2a) states in part:

> (2) Qualified aliens who first physically entered the U.S. after August 21, 1996 cannot receive TANF, Medicaid, or SCHIP for 5 years after obtaining status as a qualified alien, unless they are any of the following:
>
> (a) An alien as described under WAC 388-424-0005 (3)(b), (d), (e), (g), or (h)…

03-20

The Department of Social and Health Services, Division of Childcare and Early Learning, does not have adequate internal controls over support for payments made to licensed family home providers and assurance that all recovered overpayments are credited to the proper funding source.

Background

The Department of Social and Health Services administers child care programs that pay child care centers and licensed family home child care providers for child care services for eligible families. The Department either pays the providers directly or pays clients directly, with the expectation that the clients then will use the funds for child care services. The Department has assigned responsibility for the Program to the Economic Services Administration, Division of Child Care and Early Learning.

Program payments to vendors and clients are made from both state and federal funds. During fiscal year 2003, total expenditures were as follows:

Funding Source	**Working Connections Child Care and Seasonal Child Care**
State	$46,936,174
Federal – CFDA 93.575 – Child Care Development Fund – Discretionary	8,216,996
Federal – CFDA 93.575 – Child Care Development Fund – the amount transferred from Temporary Assistance for Needy Families funding into the child care program.	102,795,525
Federal – CFDA 93.596 – Child Care Mandatory Fund	38,488,278
Federal – CFDA 93.596 – Child Care Matching Fund	20,721,728
Federal – CFDA 93.558 – Temporary Assistance for Needy Families	75,565,807
Federal – CFDA 93.667 – Social Services Block Grant	1,031,110
Federal Recoveries	20,204
Total Subsidy Payments	**$293,775,822**

Support for payments*:*

All providers are required to keep daily attendance records. These records determine the number of hours or days of service each child is in care. The daily attendance records are used as payment support for all state and federally subsidized children. These records are to be kept on file for five years and are subject to inspection upon the Department's or the State Auditor's request.

The Division requires child care centers to have the parent or custodian of the child sign the child in and out of care and note the time of arrival and departure. The Division does not require the same information from licensed family home child care providers.

We issued special investigation report No. 6370 on May 28, 2003. In this report, we communicated our concerns regarding the inadequacy of the licensed family home providers' attendance records and recommended the recovery of the overpayments identified at that time.

Overpayments:

The Department identifies child care overpayments by reviewing reports of potential overpayments, attendance records, and client files to ensure payments are supported. The Department reports any identified overpayments to its Office of Financial Recovery.

The Department has identified a significant amount of overpayments. The overpayments, estimated at $3.2 million, consisted of approximately 25 percent provider overpayments and 75 percent client overpayments. Overpayments identified in a current fiscal year may not be recovered until a future fiscal year.

Description of Condition

During our recent review, we found the following conditions:

a. Support for payments

   The Department continues to allow licensed family home child care providers to use inadequate alternative records as support for payments issued. The alternative records we saw in recent reviews still do not require the parent or custodian to sign the child in and out of care each day and note the time the child arrived and departed. Therefore, this issue has not been resolved.

   We asked the Division Policy Director about a standardized attendance form for licensed family home child care providers and a requirement for the parent/custodian to sign children in and out of care. The Director stated the Department has not provided a standardized attendance form for family home child care providers and still does not require parental signatures. He stated many providers use the U.S. Department of Agriculture food program attendance form if they are on the food program. If not, they may make up their own.

b. Overpayments and recoveries:

   During fiscal year 2003, the Department did not ensure all funds recovered from client overpayments were returned to the proper funding source. The Department stated that approximately $684,526 was recovered from providers, $611,471 in federal funds and $73,055 in state funds. Approximately $136,000 was recovered from client overpayments. However, the Department has not been able to determine how much of this amount was initially paid with federal and state funds and to which funding source funds should be returned.

Cause of Condition

Support for payments:

The Division has not made it a priority to implement policies and procedures that would provide adequate support for payments made to licensed family home providers.

Overpayments and recoveries:

The Department has not developed a method of determining to which funding sources client overpayments should be returned.

Effect of Condition

Support for payments:

The Department cannot be assured it is paying the licensed family home child care providers only for the hours that children are actually in care. Without a standardized attendance form, licensed family home child care providers are not being held to the same reporting standard as center providers. Alternative records are subject to the interpretation of the reviewer as to whether or not services were provided, since the supporting payment document does not

include the same information as the payment report. The information recorded on the attendance record support can vary from one provider to another.

Overpayments and recoveries:

The Department may not be returning recoveries of federal funds to the proper funding sources as required by federal regulations.

Recommendation

We recommend the Department:

- Require all licensed family home child care providers use a standard attendance record issued by the Department.
- Require family home child care providers to have the parent or custodian of each child sign the standard attendance record when the child arrives and departs from care, noting the arrival and departure times.
- Ensure that all funds recouped are returned to their proper sources.

Department's Response

The State Auditor's Office issued findings that the Department continues to allow licensed family home childcare providers to use inadequate alternative records as support for payments issued. The Division of Child Care and Early Learning concurs that there are not adequate internal controls over support for payments made to licensed family home providers. Currently, the Family Child Care Home providers are not required to use a standardized DSHS form to keep attendance. The Department is changing the Family Child Care Home WAC to require parents to sign children in and out of care. The WAC revision is scheduled to be effective August 2004.

The State Auditor's Office issued findings that the Department did not ensure all funds recovered from client overpayments were returned to the proper funding source. The Division of Child Care and Early Learning does not concur with this finding. At the time that a recovery is collected, the Office of Financial Recovery codes the recovery to the original line of coding used for the expenditure. This assures that the recovery is treated as a reduction in expenditure. This was communicated to the State Auditor's Office numerous times throughout the audit, however an understanding was never effectively acknowledged.

Auditor's Concluding Remarks

We appreciate the Division's efforts in revising the Washington Administrative Code to have the parent or custodian of each child sign children in and out of care. We recommend this is done on a standard attendance record issued by the Department and that the parent notes the arrival and departure times and that periodic review of the attendance records be performed by the Department.

Our concern is the Division does not have a system in place to show that recoveries have been credited to the correct funding sources. While the Division may know the total amount of recoveries they could not show what portion was state and federal. The Division stated that in May 2003 they began the development of such a monitoring system, however for the majority of fiscal year 2003, this was not in place. We will review this area in our fiscal year 2004 audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C, Basic Guidelines, states in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria: …

    j. Be adequately documented. …

4a. Applicable credits refer to those receipts or reductions of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs. Examples of such transactions are:…rebates or allowances, recoveries or indemnities on losses,...charges. To the extent that such credits accruing to or received by the governmental unit relate to allowable costs, they shall be credited to the Federal award either as a cost reduction or cash refund, as appropriate.

03-21

The Department of Social and Health Services, Division of Developmental Disabilities, made inappropriate payments to a for-profit agency with which it has a contract to provide services to its clients.

Background

The Department of Social and Health Services, Division of Developmental Disabilities, contracts with for-profit and non-profit agencies to provide supported living services to some of its clients. Supported living services allow clients to live independently while receiving assistance in performing their daily activities, such as paying bills or preparing meals. The Division reimburses the for-profit and non-profit agencies for expenses associated with these services. Reimbursements are made with state funds and with federal funds from Medicaid (CFDA 93.778). With some exceptions, clients are expected to pay for their own rent, utilities and food.

During the past year, we received information from a concerned citizen asserting improper accounting activities on the part of one of the agencies providing supported living services. The citizen reported that the agency requested and received Division reimbursement for inappropriate and/or unsupported charges for 2000 and 2001.

Description of Condition

We found the for-profit agency improperly included charges on its 2000 and 2001 cost reports for office rent and utilities, even though the costs cited were actually client rent and utility expenses that already had been reimbursed to the agency by its clients. We also found the agency included costs for staff lodging that were not supported by documentation and costs for ineligible activities such as preparation of a personal income tax return and repairs and maintenance to a landlord's facility. For the two years, the Division overpaid the agency a total of $84,724 because of these improper charges on the cost reports.

Cause of Condition

The Division did not adequately monitor the agency's cost reports to ensure they included only proper charges.

Effect of Condition

The Division paid the agency more than the amount to which it was entitled. We question the $84,724 in improper amounts included on the agency's cost reports. The following chart presents the total payments the Division made to the agency, the amount we are questioning and the state and federal portions of those questioned costs.

	Amount reimbursed by Division	Amount in question	State portion of questioned costs	Federal portion of questioned costs
2000	$ 885,954	$13,431	$ 6,470	$ 6,961
2001	977,075	71,293	35,148	36,145
Total	$1,863,029	$84,724	$41,618	$43,106

Recommendations

We recommend the Division:

- Monitor its contracts to ensure payments are proper.
- Pursue recovery of the 2000 and 2001 costs from the applicable agency and determine whether similar costs were improperly reported in succeeding years.
- Ensure costs recovered are returned to the appropriate funding sources.

Department's Response

The Department of Social and Health Services, Division of Developmental Disabilities, concurs with this finding.

The Division has been working with the for-profit agency in determining the actual overpayment amount due and methods of refunding these monies to DSHS for the 2000 and 2001 years. The Division has also reviewed the 2002 cost report in light of the SAO findings and with the cooperation of the for-profit agency management, has made adjustments to reflect actual and allowable costs.

The Division will review and address the items noted under the Cause of Condition section of the finding. Internal controls will be reviewed with regard to the monitoring of the DDD contracts and enhanced where necessary; the questioned costs identified for years 2000 and 2001 will be recovered and returned to the appropriate funding agency.

Auditor's Concluding Remarks

We appreciate the Department's prompt and thorough response and the cooperation of Division staff provided us during this audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart C, Section .300 states in part:

> The auditee shall…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs…

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart A, Section .105 states in part:

> Questioned cost means a cost that is questioned by the auditor because of an audit finding…(2) Where the costs, at the time of the audit, are not supported by adequate documentation....

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment C, states in part:

> 1…To be allowable under Federal awards, costs must meet the following general criteria:
>
> a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
>
> c. Be authorized or not prohibited under State or local laws or regulations.

The Office of Financial Management *State Administrative and Accounting Manual*, Section 85.32.10 states in part:

> ...At a minimum, agencies are…to establish and implement the following:
>
> 1. Controls to ensure that all expenditures/expenses and disbursements are for lawful and proper purposes….

03-22

The Department of Social and Health Services, Mental Health Division, did not properly monitor its contract with a non-profit agency whose funds were used for the personal expenses of a staff member.

Background

The Department of Social and Health Services, Mental Health Division, contracted with the National Alliance for the Mentally Ill, a mental-health consumer group, to provide services to the Division's clients. Funds for this contract in the amount of $165,000 were completely provided by the federal Community Mental Health Block Grant (CFDA 93.958) during the period July 2001 through December 2002. During that time period, the Alliance also received other funding from private sources.

According to the Statement of Work, the Alliance was to use the Division funds to provide:

- Incentive grants for the growth and development of Affiliate programs and memberships.
- Outreach and educational programs.
- Activities and benefits around the state.

The contract stated the Alliance was to submit oral and written reports to the Division every six months, describing the history, status and expectation of each contracted budget item, as well as steps taken to support the quality, diversity, and geographical requirements of the contract.

In 2002, the Alliance realized funds were missing. In January 2003, the Alliance contracted with a private certified public accounting firm to conduct a special-purpose examination to determine the extent of the loss. The firm found an Alliance staff member had issued and cashed unauthorized checks in the amount of $147,060. This staff member later acknowledged taking Alliance funds for her personal expenses.

Description of Condition

The Division did not adequately monitor contract compliance or determine if the Alliance's activities and expenditures were appropriate under contract terms and conditions. The Division did not require the Alliance to submit supporting documentation for expenditures or semi-annual progress reports before the Division issued payments. In addition, the Division did not document any site visits or other monitoring methods. In some instances, the Division released payments to the Alliance in advance of the time period stated in the contract, possibly resulting in the Alliance receiving the funds before reimbursement was needed.

Cause of Condition

The Department is uncertain why the Division did not follow the Department's Administrative Policy 13.11, General Contract Monitoring.

Effect of Condition

The Division paid the Alliance for services without knowing whether they were performed. The Division does not know whether Division funds were part, or all, of the misappropriated funds. Because the use of the funds is unknown, we are questioning the entire $165,000.

Recommendations

We recommend the Division:

- Monitor to ensure contractors are complying with contract requirements.
- Ensure it is receiving the services for which it has contracted.

Department's Response

The Department concurs with the finding, the questioned costs and the recommendations. The Mental Health Division has made many improvements to contract monitoring which include: Centralizing parts of field contracting to headquarters, increased staff training and continued risk assessments to measure and implement corrective action steps. The Division will seek reimbursement from the contractor.

Auditor's Concluding Remarks

We appreciate the Department's prompt and thorough response and the cooperation of Division staff provided us during this audit.

Applicable Laws and Regulations

U.S Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations,* Subpart C, Section .300 states in part:

> The auditee shall…
>
> (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of it Federal programs…

U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Subpart A, Section .105 states in part:

> Questioned cost means a cost that is questioned by the auditor because of an audit finding…(2) Where the costs, at the time of the audit, are not supported by adequate documentation…

U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments,* Attachment C, states in part:

> 1…To be allowable under Federal awards, costs must meet the following general criteria:
>
> a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
>
> c. Be authorized or not prohibited under State or local laws or regulations.

The Office of Financial Management *State Administrative and Accounting Manual,* Section 85.32.10, states in part:

> …At a minimum, agencies are…to establish and implement the following:
>
> 1. Controls to ensure that all expenditures/expenses and disbursements are for lawful and proper purposes…

The Department's Administrative Policy 13.11, General Contract Monitoring**,** states its purpose is to provide Department of Social and Health Services (DSHS) staff with general contract monitoring guidance that can reasonably ensure: (1) the department receives goods and services that are paid through the contracting process, and (2) the contractor meets the scope of work and specifications identified in the contract.

03-23

The University of Washington did not comply with federal cost principles for its research and development programs.

Description and Cause of Condition

The University of Washington has approximately 470 organizational units that receive federal assistance for research and development programs. Federal grants are audited in accordance with federal standards that require questioned costs in excess of $10,000 be reported. In the course of our audit of 14 of these organizational units, we noted exceptions in two, totaling $35,976.59, as documented below:

Parenting Clinic

The Parenting Clinic provides programs designed to enhance children's social skills and to reduce behavior problems. It is housed in a rented space off campus. Two inter-related federal grants that total approximately $10 million pay for the programs. One grant funds evaluation of the Clinic's parent, teacher, and child training and intervention programs in Head Start centers. The other grant funds evaluation of the same programs in kindergarten and first grade. This is the third year of a five-year project.

We noted the following regarding costs charged to these two federal grants:

a. Rent was allocated entirely to one grant for a year and entirely to the other grant for another year, with the expectation that costs would be shared equally between the two grants over the life of the projects. However, we determined that costs should have been split 56 percent to 44 percent based on use of the space.

b. Due to a coding error, use tax and indirect costs were improperly assessed against the grant for school-aged children.

c. Telephone costs (telephone lines, telephones, etc.) were inaccurately distributed to the two grants.

d. Grant programs shared supplies and materials. Because of the interrelationship of the grants, it was not possible to account for actual usage of these materials by grant. The Clinic charged all duplication costs to the grant for school-aged children until March 2003, when it began charging them to the grant for Head Start centers. The costs of other supplies and materials were allocated substantially proportionate to the level of funding provided by each grant. We determined costs should have been distributed 63 percent to 37 percent based on enrollments in the programs.

e. Gift cards were used to compensate families for participation in the research programs. However, an inventory of these gift cards was not maintained by grant. The cost of gift cards was allocated almost equally between the two grants without regard to actual usage.

Applied Physics Lab

The Applied Physics Lab is the largest single recipient of federal assistance within the University, having received approximately $41 million in the past year. It conducts basic and applied research, development, engineering and education for science, industry and national defense.

One project, the 2003 Ice Camp, supported Navy test operations and work by civilian scientists monitoring changes in the Arctic. Overtime worked by University employees engaged in this project was communicated to the Payroll Coordinator in an e-mail from the Research Coordinator. Due to a miscommunication between these two individuals regarding the calculation and reporting of overtime, and the lack of any detail in the e-mail as to the number of overtime hours worked each day, two employees were overpaid a total of $5,020.55.

Effect of Condition

These conditions resulted in $28,431.36 of questioned costs charged to CFDA 93.361, $6,791.75 of questioned costs charged to CFDA 12.000, Contract N00024-02-D-6602/0020 MOD03 and $753.48 of questioned costs charged to CFDA 93.279.

Subsequent to our audit, the Parenting Clinic established a system to separately track the use of gift cards by grant. The University made appropriate transfers and adjustments to correctly allocate costs and remove unallowable charges from affected grants. It also entered into agreements to recover overtime payments.

Recommendations

We recommend:

- The Parenting Clinic take steps to ensure the accurate allocation of costs to its grants. These steps should include adequate training and guidance for the Clinic's Research Coordinator.

- The Applied Physics Lab revise its procedures to require detail reporting of overtime hours worked by employees.

University's Response

We agree. The Parenting Clinic has developed methods to allocate costs to its grants; administrative review of the distribution will be done quarterly. The budget coordinator for the Clinic is scheduled to attend university-sponsored training and will meet regularly with department administration for guidance on grants management. APL is revising its weekly time sheet forms so that overtime-eligible employees will be required to provide daily detail on any overtime hours worked. Until the revised time sheet forms are available, APL has implemented an interim reporting procedure to obtain a daily record of overtime hours worked.

Auditor's Remarks

We appreciate the University's response. We will review the University's corrective actions during the next regularly scheduled audit.

Applicable Laws and Regulations

U.S. Office of Management and Budget Circular A-21, *Cost Principles for Educational Institutions*, Section C, which requires costs to be reasonable and allocable to the sponsored agreement, defines allocable costs in subsection 4.a as:

> A cost is allocable to a particular cost objective (i.e., a specific function, project, sponsored agreement, department, or the like) if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received or other equitable relationship. Subject to the foregoing, a cost is allocable to a sponsored agreement if (1) it is incurred solely to advance the work under the sponsored agreement; (2) it benefits both the sponsored agreement and other work of the institution, in proportions that can be approximated through use of reasonable methods, or (3) it is necessary to the overall operation of the institution and, in light of the principles provided in this Circular, is deemed to be assignable in part to sponsored projects.

U.S. Office of Management and Budget Circular A-21*, Cost Principles for Educational Institutions*, Section C, subsection 4.d further states:

> (1) *Cost principles*. The recipient institution is responsible for ensuring that costs charged to a sponsored agreement are allowable, allocable, and reasonable under these cost principles.
>
> (2) *Internal controls*. The institution's financial management system shall ensure that no one person has complete control over all aspects of a financial transaction.

(3) *Direct cost allocation principles*. If a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost should be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding subsection b, the costs may be allocated or transferred to benefited projects on any reasonable basis, consistent with subsections d.(1) and (2).